STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325066	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Nursing and Rehabilitation Center	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide wound care as ordered by the physician for 1 (R #25) of 1 (R #25) resident reviewed for wound care. This deficient practice could likely cause wounds to worsen or become infected which could lead to sepsis (a serious condition in which the body responds improperly to an infection) and hospitalization. The findings are: A. Record review of R #25's face sheet revealed R #25 was admitted to the facility on [DATE]. She was admitted with the following diagnoses: Atrial Fibrillation (A-Fib; irregular heart rhythm), Type II diabetes (a disease in which the body cannot make or properly use insulin), Chronic venous hypertension with ulcer and inflammation of the left lower extremity (venous ulcers are open skin lesions that occur in an area affected by venous hypertension caused by poor blood flow and circulation), Pulmonary hypertension (condition characterized by high blood pressure in the arteries of the lungs, leading to various symptoms and potential heart complications). B. Record review of R #25's physician orders indicated the following, wound care to left lower extremity (LLE), cleanse entire foreleg (front of the leg) with generic wound cleanser and pat dry with sterile gauze. Apply silver collagen sheet (used to assist in the wound healing process). Cover with Hydrogel dressing (moist wound care products that provide hydration, pain relief and infection prevention) secure in place with kerlix (used in wound care applications) and tape, dated/initialed. Every day shift for LLE Venous Stasis Ulcers for 2 Weeks. Notify wound team of any +/- (positive or negative) wound changes. Start 11/20/25. C. On 12/04/25 at 11:05 am, during an interview and observation with R #25, she stated that everything at the facility was going well except her wound dressing had not been changed recently. R #25 stated she thinks that she is supposed to get wound care every day. R #25 revealed the wound dressing on her LLE was dated 11/26/25 and it had initials and a date of who completed the wound care. D. Record review of R #25's Treatment Administration Record (TAR) from 11/25/25 to 12/03/25 indicated the following: 11/25/25 the TAR did not have any documentation for wound care being completed, 11/26/25 to 11/29/25 wound care was marked as completed, 11/30/25, 12/01/25, 12/02/25 the TAR did not have any documentation of wound care being completed, 12/03/25 wound care was marked as completed. E. On 12/04/25 at 11:15 am during an observation and interview with the Director of Nursing (DON) she confirmed the dressing on R #25's LLE was dated 11/26/25 with initials. The DON also confirmed the TAR for November 2025 indicated wound care was completed for R #25 on 11/27/25, 11/28/25, 11/29/25 and for December on 12/03/25 but stated the documentation was not accurate because wound care was not provided on those days. The DON stated the order was to do wound care daily and it was not completed daily. F. On 12/04/25 at 11:20 am, during an interview with Licensed Practical Nurse (LPN) #8, she stated the nurses are responsible for the wound care except on Wednesdays when the wound care team rounds (all the wounds in the building are assessed) and does wound care and assessments for all the wounds. She stated that the last time she performed wound care for R #25 was on Saturday 11/29/25. She was off on Sunday, Monday and Tuesday and wasn't able to do it yesterday. LPN #8 was not able to explain why the dressing date for R #25's LLE wound was dated 11/26/25, when her initials on the TAR indicated she performed wound care for R #25 on 11/27/25, 11/28/25, 11/29/25 and on 12/03/25. G. On 12/04/25 at 11:45 am, during an interview with the Wound Care Nurse, he stated the last time he performed wound care for R #25 was on 11/26/25. He stated Wednesday are wound assessment days and he and the wound care team do assessments and wound care for the whole building. The wound nurse stated he was the last nurse to have completed wound care for R #25 according to the wound dressing. The wound nurse stated, staff know and are aware if they are needing help with anything they can always ask him for help. He stated none of the nurses on the floor have asked for assistance from him and he was not aware there were issues with the wound care being completed. H. Record review of R #25's wound assessment completed on 12/04/25 revealed the wound had not deteriorated (gotten worse) since the last wound care completed on 11/26/25.

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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 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** Based on observation, interview, and record review; the facility failed to accurately record (document what actually occurred) the wound care for 1 (R #25) of 1 (R #25) resident reviewed for wounds. This deficient practice is likely to cause confusion about wound care, when wound care documentation is inaccurate and indicates wound care treatments as being completed when they were not. The findings are: A. Record review of the R #25's face sheet revealed R #25 was admitted to the facility on [DATE]. She was admitted with the following diagnoses: Atrial Fibrillation (A-Fib; irregular heart rhythm), Type II diabetes (a disease in which the body cannot make or properly use insulin), Chronic venous hypertension with ulcer and inflammation of the left lower extremity (venous ulcers are open skin lesions that occur in an area affected by venous hypertension caused by poor blood flow and circulation), Pulmonary hypertension (condition characterized by high blood pressure in the arteries of the lungs, leading to various symptoms and potential heart complications). B. Record review of R #25's physician orders dated 11/20/25 revealed the following: - Wound care to left lower extremity (LLE), cleanse entire foreleg with generic wound cleanser and pat dry with sterile gauze. Apply silver collagen sheet (a type of wound dressing) to open areas. Cover with Hydrogel (wound dressing designed to provide a moist environment for wound healing) dressing, secure in place with kerlix (bandage roll) and tape, dated/initialed. Every day shift for LLE Venous Stasis Ulcers (wounds caused by a lack of blood circulation to the lower extremities) for 2 Weeks. Notify wound team of any +/- (positive or negative) wound changes. C. On 12/04/25 at 11:05 am, during an interview and observation with R #25, she stated that everything at the facility was going well except her wound dressing had not been changed recently. R #25 stated she thinks that she is supposed to get wound care every day. R #25 revealed the wound dressing on her LLE was dated 11/26/25 and it had initials and a date of who completed the wound care. D. Record review of R #25's Treatment Administration Record (TAR) from 11/27/25 to 12/03/25 indicated the wound care to the LLE was completed, and marked with the nurses' initials that completed the wound care on the following dates: - 11/20/25 through 11/24/25. - 11/26/25 through 11/29/25. - 12/03/25. E. On 12/04/25 at 11:15 am during an observation and interview with the Director of Nursing (DON) she confirmed the dressing on R #25's LLE was dated 11/26/25 with initials. The DON also confirmed the TAR for November 2025 indicated wound care was completed for R #25 on 11/27/25, 11/28/25, 11/29/25 and for December on 12/03/25 but stated the documentation was not accurate because wound care was not provided on those days. The DON stated the order was to do wound care daily and it was not completed daily. F. On 12/04/25 at 11:20 am, during an interview with Licensed Practical Nurse (LPN) #8, she stated the nurses are responsible for the wound care except on Wednesdays when the wound care team rounds (all the wounds in the building are assessed) and does wound care and assessments for all the wounds. She stated that the last time she performed wound care for R #25 was on Saturday 11/29/25. She was off on Sunday, Monday and Tuesday and wasn't able to do it yesterday. LPN #8 was not able to explain why the dressing date for R #25's LLE wound was dated 11/26/25, when her initials on the TAR indicated she performed wound care for R #25 on 11/27/25, 11/28/25, 11/29/25 and on 12/03/25.