

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER St Anthony Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 West 21st Street Clovis, NM 88101	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207</p> <p>Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed. If the facility is not updating the care plan to reflect the treatment needs for wound care, then the residents could likely experience a worsening of existing wounds or the development of new wounds. The findings are:</p> <p>A. Record review of R #1's Admission Record revealed R #1 was admitted to the facility on [DATE] with the following multiple diagnosis:</p> <ol style="list-style-type: none"> 1. Unspecified fracture of shaft humerus (break in the long bone of the upper arm), unspecified arm, subsequent encounter for fracture with routine healing. 2. Type 2 diabetes mellitus without complications. 3. Long term (current) use of insulin (a hormone that regulates blood sugar levels by moving glucose from the blood into cells). 4. Long term (current) use of anticoagulants (a substance that is used to prevent and treat blood clots). 5. Pressure ulcer (an injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral region (the portion of the spine between the lower back and the tailbone), Stage 3 (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone). <p>B. Record review of R #1's entry Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 09/28/24, revealed R #1 was admitted to the facility with one Stage 3 pressure ulcer. The location of the Stage 3 pressure ulcer on R #1's body was not listed.</p> <p>C. Record review of R #1's care plan, revealed the following interventions were added to the plan on 10/19/24:</p> <p>- R #1 had actual skin breakdown.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Type: Stage 3 pressure ulcer to coccyx, and surgical incision to back of neck upon admission.</p> <p>- In-house acquired (developed at the facility): Stage 3 to left heel, deep tissue injury (DTI) to right heel.</p> <p>D. On 10/31/24 at 10:10 am, during an interview with the Director of Nursing (DON), she confirmed interventions for wound care were not included in R #1's care plan until 10/19/24, see finding C. She stated including needed interventions into a care plan twenty-five days after admission did not meet her expectations. The DON stated staff should have completed the resident's comprehensive care plan within seven days of the comprehensive assessment (MDS). She stated R #1's care plan was not comprehensive, because it did not include needed interventions for pressure ulcers.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207</p> <p>Based on record review and interview, the facility failed to provide a discharge summary that included a recapitulation (a summary describing the resident's course of treatment while residing in the facility) and a reconciliation of all medications at the time of discharge for 1 (R #1) of 1 (R #1) resident reviewed for discharge. This deficient practice could likely lead to the receiving facility, community agency, or family member not knowing what the current care needs and/or current medications are for the resident. The findings are:</p> <p>A. Record review of R #1's Admission Record revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> - Unspecified fracture of shaft humerus (break in the long bone of the upper arm), unspecified arm, subsequent encounter for fracture with routine healing. - Type 2 diabetes mellitus without complications. - Long term (current) use of insulin (a hormone that regulates blood sugar levels by moving glucose from the blood into cells). - Long term (current) use of anticoagulants (a substance used to prevent and treat blood clots). - Pressure ulcer (an injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral region (the portion of the spine between the lower back and the tailbone), Stage 3 (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone). <p>B. Record review of R #1's History and Physical (H &P) assessment, dated 10/16/24, revealed orders to discontinue atorvastatin calcium (medication used to lower high cholesterol and triglycerides), heparin sodium (blood thinner), docusil (stool softener), senna (laxative), and tamsulosin HCl (medication to treat an enlarged prostate).</p> <p>C. Record review of R #1's Physician Progress Note, dated 10/17/24, revealed R #1's cast was removed and can start using his arm for activities.</p> <p>D. Record review of R # 1's Electronic Health Record revealed R #1 was discharged from the facility on 10/24/24.</p> <p>E. Record review of R #1's Discharge Transition Plan, not dated, revealed a Medication Administration Record (MAR), dated October 2024, attached as R #1's current medication list. The record included the following:</p> <ul style="list-style-type: none"> - The MAR was printed on 10/11/24 at 1:36 pm: thirteen days before R #1 discharged from this facility. <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The MARs included the following discontinued medications (per the resident's H&P dated 10/16/24):</p> <ol style="list-style-type: none"> 1. An order for atorvastatin calcium tablet, 40 milligrams once daily for cholesterol. 2. An order for heparin sodium solution, Inject 1 milliliter subcutaneously (under the skin) two times a day for prevention of blood clots. 3. An order for docusil oral capsule, 100 milligrams by mouth twice daily for stool softener. 4. An order for senna oral tablet 8.6 milligrams twice daily for constipation. 5. An order for tamsulosin HCl oral capsule 0.4 milligrams once daily for blood pressure. <p>F. Record review of R #1's Discharge Plan, not dated, revealed the following:</p> <ul style="list-style-type: none"> - A diagnosis of unspecified fracture of shaft humerus. - Skin conditions: <ol style="list-style-type: none"> 1. Stage 3 pressure ulcer to coccyx (tail bone located at the end of the spine). 2. Stage 3 pressure ulcer to left heel. 3. Deep tissue injury (DTI) to right heel. - The plan did not list any medication, any current orders, or any recommendations for care for the skin conditions listed. - The plan did not include information from the Physician Progress Note, dated 10/17/24, allowing R #1 to use his arm for activities. <p>G. Record review of R #1's admission skin assessment at the receiving facility, completed on 10/24/24 at 5:31 pm, revealed staff documented the following:</p> <ol style="list-style-type: none"> 1. A pressure ulcer on his sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis) which measured 11 x 10 centimeters (cm) was unstageable due to black eschar. 2. A pressure ulcer on his left heel measuring 2.7 x 2.3 cm and was unstageable with brown eschar (dark, crusty tissue that forms on top of a wound). 3. A pressure ulcer on his right heel measuring 4.6 c 4.5 cm. 4. R #1 had a pressure ulcer on the right elbow, with dry scab over the olecranon process (the upper end of the ulna bone that forms the elbow), which measured 1.0 centimeters (cm) by (x) 0.8 cm and surrounded by purple-red discoloration in 3 x 3 cm circumference around the scab. Appeared pressure related. <p>(continued on next page)</p>		

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