STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325076	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony Healthcare and Rehabilitation Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide respiratory care in accordance with professional standards for 4 (R #2, R #3, R #5, and R #6) of 4 (R #2, R #3, R #5, and R #6) residents reviewed for respiratory care when the staff failed to:1. Ensure medical orders included the amount of oxygen (a specific flow rate; measurement of the volume of liquid or gas moving per unit of time) and the delivery method (i.e. Nasal canula, simple mask, or non-rebreather mask) for R #6.2. Ensure oxygen tubing included a label with a date indicating when tubing was changed for R #2, R #3, and R #5).These deficient practices are likely to result in residents receiving too much, not enough oxygen, and increase their risk of infection which can lead to worsening of their conditions.The findings are:A. Record review of the facility's Oxygen Concentrator policy, revised on 08/07/23, revealed the following:1. All oxygen components should be labeled and dated.2. The first step to setting up oxygen is to verify orders. R #2B. Record review of R #2's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/14/26, revealed the following:1. R #2 was admitted to the facility on [DATE].2. R #2 had the following diagnoses:-Respiratory failure with hypoxia (a condition where body tissues do not receive enough oxygen to function properly),-Atrial fibrillation (A-Fib; irregular heart rhythm),-Congestive heart failure (CHF; impaired heart function). C. On 06/30/26 at 10:32am, during a random observation, R #2 was sitting in her wheelchair in the activities area. R #2 was wearing a nasal cannula connected to an oxygen tank. The oxygen tubing did not contain a label or a date. D. Record review of R #2's oxygen tubing order, dated 02/22/26, revealed oxygen tubing was to be changed weekly and label each component with date and initials every Sunday night shift. E. On 06/30/26 at 10:33 am, during an interview, the Business Office Manager (BOM) stated the oxygen tubing did not have a label or a date. F. On 07/01/26 at 1:01 p.m., during an interview, the Director of Nursing (DON) stated the lack of labeling on Resident #2's oxygen tubing did not meet her expectations. She stated all oxygen tubing was required to be changed weekly and when visibly soiled. R #3G. Record review of R # 3's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Respiratory failure with hypoxia (a condition where body tissues do not receive enough oxygen to function properly),2. Chronic Obstructive Pulmonary disease (COPD; lung disease),3. Congestive heart failure (CHF; impaired heart function). H. On 06/30/26 at 10:37 am, during an observation, R # 3 was sitting in a wheelchair during physical therapy. R #3 was wearing a nasal cannula connected to oxygen during physical therapy, the oxygen tubing did not have a label or a date on the tubing. I. Record review of R #3's oxygen tubing order, dated 06/26/26, revealed oxygen tubing was to be changed weekly and to label each component with date and initials every Sunday night shift. J. On 06/30/26 at 10:38 am, during an interview, the Occupational Therapy Assistant (OTA) stated the oxygen tubing did not have a label or a date. K. On 07/01/26 at 1:01 p.m., during an interview, the DON stated the lack of labeling on Resident #3's oxygen tubing did not meet her expectations. She stated all oxygen tubing was required to be changed weekly and when visibly soiled. R #5L. Record review of R #5's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 03/25/26, revealed the following:1. R #5 was admitted to the facility on [DATE].2. R #5 had the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following diagnoses:-Respiratory failure with hypoxia (a condition where body tissues do not receive enough oxygen to function properly),-Chronic Obstructive Pulmonary disease (COPD; lung disease). M. On 06/30/26 at 10:39 am, during an observation, R #5 was sitting in a wheelchair outside his room. R #5 had a nasal cannula was connected to oxygen tank, the oxygen tubing did not have a label or a date on the tubing. N. On 06/30/26 at 10:38 am, during an interview, the Certified Medication Aide (CMA) stated the oxygen tubing was not labeled or dated. O. On 07/01/26 at 1:01 p.m., during an interview, the DON stated the lack of labeling on Resident #5's oxygen tubing did not meet her expectations. She stated all oxygen tubing was required to be changed weekly and when visibly soiled. R #6P. Record review of R # 6's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Anemia (not enough healthy red blood cells),2. End stage renal disease (ESRD; chronic irreversible kidney failure),3. Congestive heart failure (CHF; impaired heart function). Q. Record review of R #6's physician order for oxygen, dated 06/26/26, revealed the order did not include a flow rate or an oxygen delivery device [i.e. nasal cannula, simple mask, or non-rebreather mask]. R. On 07/01/26 at 1:01 pm, during an interview, the DON stated oxygen orders should contain appropriate information to ensure residents receive the appropriate amount of oxygen and by which device. She stated this order does not meet her expectations.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely acquisition and provision of ordered narcotic pain medication for 1 (R #6) of 1(R #6) resident who required postˆoperative pain management. This failure resulted in a delay in receiving prescribed narcotic medication which has the potential to cause the resident unnecessary pain and anguish. The findings are:A. Record review of the facility's Medication Ordering and Receiving From Pharmacy Provider, Ordering and Receiving Controlled Medications policy, dated 01/2023, revealed the Drug Enforcement Agency (DEA) requires a pharmacy must have a valid prescriber signed prescription in order to dispense controlled substances. In emergency situations, verbal authorization may be given by the prescriber to the pharmacist for a new order. B. Record review of R # 6's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Surgical Amputation,2. End stage renal disease (ESRD; chronic irreversible kidney failure),3. Osteomyelitis (inflammation of bone and bone marrow). C. Record review of the electronic health record, revealed R #6 was admitted on [DATE] at 4:06 pm after surgical amputation of left leg above the knee on 06/17/26, left long finger amputation on 06/13/26, and right long finger, ring finger, and small finger amputations on 06/11/26. R #6 complained of 10/10 (pain scale using 0-10, zero being no pain and 10 is the worst it can be) pain. D. Record review of R #6's physician orders for pain revealed the following:1. An order, dated 06/26/26, for celecoxib (anti-inflammatory drug) 200 milligrams (mg), give 1 capsule by mouth one time a day for pain [start 06/27/26 at 8:00 am; end indefinite].2. An order, dated 06/26/26, for gabapentin (anticonvulsant (medication used to prevent control or stop seizures and convulsions) and nerve pain medication) 100 mg, give 1 tablet two times a day for pain [start 06/26/26 at 8:00 pm; end indefinite].3. An order, dated 06/26/26, for hydrocodone-acetaminophen (combination pain medication) 5 mg/325 mg, give 1 tablet by mouth every 4 hours as needed for pain [06/26/26 at 5:45 pm; end indefinite].4. An order, dated 06/26/26, for pregabalin (medication for anticonvulsant and neuropathic pain medication) 75 mg, give 1 capsule by mouth at bedtime for pain [start 06/26/26 at 8:00 pm; end indefinite].5. An order, dated 06/26/26, for capsaicin (topical pain reliever) external cream 0.025%, apply to leg topically every 8 hours as needed for pain up to three times a day [06/26/26 at 5:45 pm; end indefinite].6. An order, dated 06/26/26, for Acetaminophen 325 mg give 2 tablets every four hours as needed for pain [start 6/26/26 at 5:30 pm; end 6/27/26 at 1:45 am].7. An order, dated 06/26/26, for Tylenol 500 mg give 2 tablets every eight hours as needed for pain [start 6/26/26 at 2:00 am; end 6/27/26 at 2:26 am].8. An order, dated 06/26/26, for Tylenol 500 mg give 2 tablets by mouth one time only for pain for 3 days [start 6/27/26 at 10:00 am; end 6/27/26 at 2:26 am].9. An order, dated 06/26/26, for Tylenol 500 mg give 2 tablets every one time only for pain for 3 days [6/27/26 at 11:00 am; end indefinite]. E. Record review of R #6's medication administration record (MAR) revealed the following:1. On 06/26/26 at 5:30 pm, Acetaminophen 650 mg given.2. On 06/26/26, Capsaicin cream was not administered.3. On 06/27/26 at 8:00 pm, Gabapentin 100mg given.4. On 06/26/26 at 9:02 pm, two tablets of Acetaminophen 325 mg were given.5. On 06/26/26, Hydrocodone-Acetaminophen was unavailable from the pharmacy.6. On 06/27/26 at 8:15 am, Hydrocodone-Acetaminophen was given.7. Pregabalin 75 mg was not administered because it was unavailable from the pharmacy. F. Record review of progress notes revealed the following: 1. On 06/26/26 at 4:05 pm, R #6's reported 10/10 pain, distraction techniques utilized, resident position changed, as needed (PRN) medication provided.2. On 06/26/26 at 6:18 pm, the medication was ineffective.3. On 06/26/26 11:07 pm pregabalin was pending pharmacy delivery.4. On 06/26/26 23:39 pm RN #1 documented: a. At 4:19 pm attempt to get narcotic medication filled by pharmacy. b. At 7:26 pm attempt to get narcotic medication filled by pharmacy. c. At 8:39 pm attempt to get narcotic medication filled by pharmacy. d. At 11:14 pm attempt to get narcotic medication filled by pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 07/01/26 at 12:00 pm, during an interview, Registered Nurse (RN) #2 stated as soon as she had the narcotic prescription signed by the physician, she sent it to the pharmacy. She stated when she was notified the prescription did not go through, she sent it again. She stated that the staff from the facility reached out again later in the evening she sent it again. She stated she did not know the prescription had still not gone through during her last conversation with the facility until the next day. H. On 07/1/26 at 12:11 pm, during an interview, RN #1 stated the resident arrived at approximately 4:00 pm and requested to have the narcotic prescription filled as soon as medication list was received. She stated an emergency kit was accessible only by a code provided by pharmacy once the narcotic prescription was received. She stated the nurse who mediated between the facility and the pharmacy indicated she was sending prescription to pharmacy. She stated she notified the physician multiple times, and the provider allowed only acetaminophen for pain, first 650 mg and then an increased dose of 1000mg. The provider also prescribed capsaicin cream to the area of pain, but stated she could not apply it because the area was a recent surgical incision site and use was contraindicated. She stated she provided the prescribed medications and repositioned the resident as often as possible. I. On 07/01/26 t a1:20 pm, during an interview, the Director of Nursing (DON) stated narcotics were not in the building for new residents until the pharmacy receives the prescription, and the pharmacy would not send narcotics for the resident until the resident was physically in the facility. She stated the process was to request the prescription through an application via phone to the company's providers. She stated the nurse mediator sent the new narcotic prescription to the physician to sign, and once signed, it would be sent to pharmacy to be filled. She stated the pharmacy reported they did not receive this prescription until the next morning. She stated this did not meet her expectations for ensuring narcotic medications were received as soon as possible.