STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 Based on interview, observation, and record review, the facility failed to keep residents free from abuse for 1 (R #4) of 4 (R #1, R #2, R #3, and R #4) residents reviewed. This deficient practice likely resulted in staff to resident abuse in which R #4 had bruising to her neck and wrists. The findings are: R #4 A. Record review of R #4's face sheet revealed she was admitted to the facility on [DATE] and was dependent on care for activities of daily living (ADLs: any of the routine tasks an individual must be capable of performing in order to function independently, as dressing, eating, moving around, and maintaining personal hygiene) Her diagnoses included but were not limited to: - Reduced mobility (severe chronic illness that requires immobilization in bed), - Need for assistance with personal care, - Acute respiratory failure, - Cellulitis (infection of skin and surrounding tissue) of right lower limb, - Acute kidney failure, - Sepsis (life threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). - Metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body). B. Record review of R #4's Admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated [DATE], revealed a Brief Interview for Mental Status (BIMS; tool to screen and identify the cognitive condition of long-term care residents 0 being the lowest and 15 being the highest) score of 12, moderate cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0600 Level of Harm - Actual harm Residents Affected - Few	C. Record review of R #4's MDS, dated [DATE], revealed a BIMS score was a 3, severe impairment, with behaviors directed towards others, verbal behaviors directed toward others, other behaviors not directed toward others (self-inflicted.) D. Record review of R #4's discharge summary, dated [DATE], revealed NP #1 indicated ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) noted to the front of the resident's upper chest. E. On [DATE] at 2:32 pm during an interview, Family Member (FM) #1 stated she visited R #4 on the night of [DATE]. She stated R #4 told her there were things going on at the facility, and they should investigate if she (R #4) died there. FM #1 stated she visited R #4 on [DATE] from approximately 4:30 pm to approximately 9:00 pm, and she did not see any bruises on R #4. She stated she remembered this because R #4 kept saying she did not want to stay there. FM #1 stated R #4 held her hand so tight that she took a photo and sent it to her daughters. She stated on the same night, at approximately 11:00 pm, she received a phone call from the facility advising her that R #4 was very agitated and inconsolable. She stated she offered several times during the phone call to go to the facility, but the caller insisted to her it was not necessary for her to come. FM #1 state the caller told her the facility contacted R #4's Hospice Nurse (HRN). FM #1 stated she received a phone call on [DATE] from HRN #5, who was R #4's primary hospice nurse. FM #1 stated HRN #5 reported she (HRN #5) saw R #4 and noted bruising around the resident's neck, on her arms, and on her hands. FM #1 stated she went to the facility, and HRN #5, a Hospice Supervisor (HS), and nurses from an outside sexual assault advocacy company were there to complete a Sexual Assault Nurse Exam (SANE) on R #4. She stated, after the exam, law enforcement was called, and the police began their investigation. FM #1 stated she had the resident transferred to another facility on [DATE], and resident passed away on [DATE]. She stated the bruising was still so bad R #4 had to have a shirt placed on backwards during funeral to hide the bruising that was still visible. F. On [DATE] at 10:04 am during an interview with HRN #5, she stated she went to the facility to do her daily rounds on [DATE]. She stated she entered R #4's room to perform an assessment and noted bruising around R #4's neck, arms, and hands. HRN #5 stated she questioned R #4 about the bruising, and R #4 replied tight hands. HRN #5 stated she spoke with the DON, but the DON was not forthcoming with information about the nurses who worked the night shift. She stated she also spoke with RN #3, the day nurse on [DATE], and he told her the information he received in report from LPN #5. HRN #5 stated RN #3 reported that LPN #5 told him R #4 scratched herself while pulling at her gown and oxygen tubing. HRN #5 stated she notified the Hospice Supervisor (HSRN) #6 and R #4's daughter/Power of Attorney (POA; a legal document giving power or the authority to act for another person in specified or all legal or financial matter) about the incident. HRN #5 stated HSRN #6 came to the facility, and they decided to call Sexual Assault Services to do an exam of the resident. HRN #5 stated R #4's daughter/POA, consented to the exam. HRN #5 stated once SANE RN #7 (the nurse from the outside agency who conducted the exam), and DON were present at the facility, the exam was performed. HRN #5 stated the DON brought LPN #4 (the nurse that assisted LPN #5 with R #4 during the night because LPN #5 couldn't calm R #4 down) back into the facility to discuss what occurred with R #4 the night before and how R #4 may have gotten the bruises. HRN #5 stated while LPN #4 was in the room she was loud and stated she hoped R #4 would have died last night. HRN #5 stated LPN #4 kept repeating herself loudly, and R #4 gave LPN #4 not a very pleasant look. HRN #5 stated HSRN #6 told LPN #4 to leave due to her inappropriate behavior and comments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0600 Level of Harm - Actual harm Residents Affected - Few	G. On [DATE] at 12:04 pm during an interview with HSRN #6, she stated HRN #5 notified her of the bruising noted on R #4 during the routine exam on [DATE]. HSRN #6 stated she went to the facility for an assessment of R #4. She stated there was bruising inside R #4's mouth and petechiae (pinpoint, round spots that form on the skin. They are caused by bleeding, which makes the spots look red, brown or purple in eye area) around her eyes. She stated there was not any bruising or marks to the back of R #4's neck, only to the front and sides of her neck. HSRN #6 stated R #4 complained of a sore throat and difficulty swallowing. She stated during their assessment and interview with R #4, the resident said she had been very angry and had thrown things. HSRN #6 stated the resident also said they had tight hands, tight hands, and they yelled at R #4 to stop yelling. HSRN #6 stated she informed the DON and LPN #2, the Unit Manager, that they would be filing a complaint with the SA. HSRN #6 stated the DON and LPN #2 told her they already filed a complaint with the SA. HSRN #6 stated she contacted R #4's daughter/POA and advised her the hospice agency would file an incident report with the SA. She stated R #4's daughter/POA stated she wanted to report the incident to law enforcement and have a SANE conducted. HSRN #6 stated while SANE RN # 7 completed the assault exam, LPN #4 came back to facility at the request of the DON. HSRN #6 stated they entered R #4's room, and LPN #4 was pretty animated describing how R #4 was yelled, spit, and grabbed at her the previous night. HSRN #6 stated R #4 became increasingly agitated by LPN #4's explanation. HSRN #6 stated LPN #4 said she prayed R #4 would die overnight. HSRN #6 stated she asked LPN #4 to leave the room, because her comments were inappropriate. H. On [DATE] at 1:04 pm and 3:04 pm, during an interview, SANE RN #7 stated the family of R #4 and the hospice staff requested a forensic exam due to the injuries R #4 sustained, and she performed the exam on [DATE]. She stated she found bruising around the resident's neck and chest area, bruising inside of her mouth, and petechiae in the area around the eyes. She stated her training taught her these findings are a result of strangulation. She stated she observed bruising on R #4's hands and wrists, and she observed some abrasions on the resident's left arm. She stated, in her professional opinion, with the length of the resident's nails, she would have expected to find abrasions and injuries of that sort had the resident injured herself. She stated she would have expected there to be some differing injuries. SANE RN #7 stated if R #4 had caused the bruising to herself then the bruising would have looked different. I. On [DATE] at 1:10 pm during an interview with RN #3, he stated when he arrived for his shift on the morning of [DATE] (6:00 am to 6:00 pm), he noted R #4's door was open. He stated R #4's gown and blankets were on the floor leaving the resident nude and uncovered. RN #3 stated he entered the resident's room and covered her. RN #3 stated he noticed redness on and around the resident's neck area. He stated the resident still appeared agitated. RN #3 stated R #4 had an order for ABH gel (a topical gel made from a combination of Ativan, Benadryl, and Haloperidol) and he applied this on her to help calm her down while he was getting report. RN #3 stated he had not spoken to the night nurse yet or received a hand-off report (when the nurse from the previous shift will tell the on-coming nurse about changes in resident, their care, or medications prior to the on-coming nurse assuming care of a resident) from LPN #5. RN #3 stated LPN #5 told him that R #4 was agitated during the evening, and R #4 pulled at her gown, threw things, and pulled at her oxygen tubing, which caused the resident's bruising. RN #3 stated LPN #5 said she required help from LPN #4 to calm down R #4. R #3 stated that when he had tried to put her oxygen tubing back on her which she pulled it off easily and without contacting her neck. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0600 Level of Harm - Actual harm Residents Affected - Few	J. On [DATE] at 4:47 pm during an interview with LPN #5, she stated she did not remember much from that night, except that R #4 was very agitated and she could not calm her down. She stated R #4 had been agitated before, but this time it went on and on. LPN #5 stated R #4 kept her gown off most of the time. K. On [DATE] at 5:28 pm during an interview, LPN #4 stated R #4 was so loud on the evening of [DATE] that she could hear the resident yelling from another part of the facility. LPN #4 stated she could hear R #4 call for staff to get her out of bed to see the babies. She stated she went to assist LPN #5 in calming the resident. LPN #4 stated when she went into R #4's room, R #4 was very agitated, had thrown off every blanket and pillow from her bed, dumped numerous cups of water onto the floor; and complained that she was very hot. LPN #4 stated she tried to plug in a fan, but R #4 immediately threw the fan across the room. LPN #4 stated R #4 pulled her gown on the right side which left a bruise on that side of the resident's neck. LPN #4 stated she tried to take the gown from R #4's hands. She stated she told R #4, You know what? Look. Can we just take this gown off? She stated R #4 decided she would just grab hold of her own skin and continually pull at it. LPN #4 stated R #4's gown was tied in the back, and the resident pulled on it with both of hands. LPN #4 stated the resident was kind of spinning the gown around, turning it all the way from left side to the right side. LPN #4 stated they asked her if they could take the gown off, and R #4 let them take it off. LPN #4 stated they tried to put a sheet over the resident, but R #4 did not allow it. LPN #4 stated they pulled the privacy curtain closed for dignity. LPN #4 stated she sat in the resident's room with Certified Nurse Aide (CNA) #2. She stated one of the bruises visible at that time looked like a start of a bruise from the gown on her neck, because the resident pulled on it so hard. LPN #4 stated the resident was very agitated and started grabbing hold of her skin with her bare hands. LPN #4 stated they gave R #4 a pillow to hold, but that did not help. LPN #4 stated R #4 wanted to get on the floor and just be out of bed. She stated R #4 pushed off everything from the tray table, she threw things and hit everything in the room with her left hand. LPN #4 stated the resident's left hand was very puffy, but it was not bruised that she could remember. She stated that while CNA #2 was in R #4's room with her, they called Hospice and the hospice nurse arrived (HRN #4). She stated HRN #4 stayed for awhile. LPN #4 stated the resident became calm while HRN #4 was with her. LPN #4 stated R #4 started screaming again as soon as HRN #4 left. LPN #4 stated she called R #4's daughter/POA that night ([DATE]) to inform FM #1 that R #4 was having a very rough evening. LPN #4 stated R #4 said she would like to die that night. LPN #4 stated she (LPN #4) did make the statement that she wished R #4 would just die, and the hospice person was in the room when she said it. L. On [DATE] at 9:34 am during an interview with HRN #4, he stated he received a call from the night shift staff on the evening of [DATE], and they stated R #4 was experiencing agitation. HRN #4 stated the staff reported they were unable to calm the resident down. HRN #4 stated he could hear yelling in the background during the phone call. HRN #4 stated he arrived at the facility on [DATE] and went to R #4's room. He stated he cared for the resident in the past, and she seemed to recognize him. HRN #4 stated R #4 appeared to become less agitated. RN #4 stated he observed fresh bruising around R #4's neck, chest area, and hands. RN #4 stated he reported the bruising to HRN #5 the next morning, because HRN #5 was the resident's primary hospice nurse. He stated during his visit R #4 remained calm and was no longer agitated. M. Record review of R #4's progress note, dated [DATE] at 1:32 am and written by LPN # 5, revealed the hospice nurse left and the resident became upset, crying out for her father again. N. Record review of R #4's physician orders, dated [DATE], revealed the following orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0600 Level of Harm - Actual harm Residents Affected - Few	- Alprazolam (medication used to treat anxiety and panic disorders), every 8 hours for restlessness or anxiety, - Haloperidol lactate oral concentrate (an antipsychotic medication used to treat certain mental and mood disorders), every 6 hours as needed for agitation, nausea, and vomiting. - Benadryl (medication to treat cold or allergy symptoms, motion sickness, and insomnia), 25 mg every 6 hours as needed for insomnia. - An order dated [DATE], for ABH gel every 4 hours as needed for anxiety. O. Record review of R #4's Medication Administration Record (MAR), dated [DATE] and [DATE] for the evening shift, revealed staff did not administer medications for anxiety, restlessness, or agitation to R #4 until after midnight when they gave her alprazolam. P. Record review of staffing schedule for LPN #4, LPN #5, and CNA #2, revealed each staff member continued to be placed on schedule to work. LPN #5 was terminated on [DATE], LPN #4 was suspended [DATE], and CNA #2 did not have a lapse in employment. Q. Repeated request for the facility's investigation of the incident were made to the Administrator, but the facility did not provide their investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 40671 Based on record review and interview, the facility failed to prevent misappropriation (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) of resident property, when a resident's pain medication was given to another resident for 1 (R #2) of 1 (R #2) residents reviewed for misappropriation. This deficient practice could likely result in residents not receiving needed medications to maintain or improve their quality of life. The findings are: R #2 A. Record review of the Narcotic Tracking Sheet for R #2 revealed the following: - On 11/06/23 at 6:00 pm, staff documented 40 milligrams (mg) of morphine (narcotic pain medication) was spilled. - Signed by the Director of Nursing (DON) and Licensed Practical Nurse (LPN)/Unit Manager #2. B. On 05/07/24 at 5:31 pm during an interview, Registered Nurse (RN) #1 stated LPN #2 went into RN #1's medication cart and told her she was looking for morphine for an emergency situation. She stated LPN #2 told her that the Nurse Practitioner (NP) gave her a verbal order to administer 2 mg of morphine to R #1. RN #1 stated she observed LPN #2 retrieve a bottle of morphine from R #2's narcotic medications, withdraw some morphine from the bottle, and administer the morphine to R #1. RN #1 stated staff documented the morphine as spilled on R #2's narcotic sheet but that was not true. RN #1 stated she held the bottle of morphine while LPN #2 withdrew the medication and watched LPN #2 administer the medication to R #1. She stated she did not observe any of the morphine spilled. C. On 05/08/24 at 10:00 am during an interview, the NP stated LPN #2 and the DON reported to her that LPN #2 took 40 mg of R #2's morphine and administered it to R #1. She stated staff documented on R #2's narcotic medication sheet that the morphine was spilled, and the DON and the LPN #2 signed the sheet. She stated the DON and LPN #2 told her they would file a report with the State Agency (SA) for a medication error, but they did not report it. D. On 05/09/24 at 3:03 pm during an interview, the Administrator (ADM) stated she was not aware LPN #2 took morphine from R #2 and administered it to another resident. She stated she expected staff to report this incident to her, but they did not. E. On 05/09/24 LPN # 2 and DON were not available for interview due to being placed on administrative leave.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34439 40671 Based on record review and interview, the facility failed to provide Facility Initiated Reports (mandatory self-initiated facility report of an incident) to the State Survey Agency (SSA) for 6 (R #1, #4, #5, #8, #9 and #10) of 8 (R #1, #4, #5, #8, #9 and #10) residents reviewed for incidents when staff failed to report the following incidents: 1) Medication error for R #1 2) Injury of unknown origin for R #4 within two hours of becoming aware of the injuries. 3) Unwitnessed falls with injuries for R #5 and #10; 4) Allegations of abuse reported by R #8 and #9; This deficient practice is likely to result in the SSA not being aware of facility incidents and unable to assure residents safety. The findings are: R #1 A. Cross reference F760 B. On 05/14/24 at 1:04 pm during interview with the Administrator (ADM), she stated the Director of Nursing (DON) was responsible to report incidents to the State Agency (SA). The ADM confirmed the medication error for R #1 was not reported. R #2 C. Cross reference F602 D. On 05/08/24 at 10:00 am during an interview, the Nurse Practitioner (NP) stated LPN #2/Unit Manager and the DON reported to her that LPN #2 took 40 milligrams (mg) of R #2's morphine and administered it to R #1. She stated staff documented on R #2's narcotic medication sheet that the morphine was spilled, and the DON and the LPN #2 signed the sheet. She stated the DON and LPN #2 told her they would file a report with the State Agency (SA) for a medication error, but they did not report it. R#4 E. Cross reference F600 F. Record review of R #4's nursing documentation, dated 4/23/2024 at 12:23 am, revealed bruising to R #4 neck. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of the facility's Incident Report, dated 4/23/24 at 5:30 pm, indicated R #4 had dark purple bruising to collar area (neck). H. Record review of the State Survey Agency's (SSA) Intake Report indicated the facility's report was received on 4/25/24 at 11:41 am for an injury of unknown origin, two days after the resident's documented injury. I. On 05/13/24 at 10:04 am during an interview with Hospice Registered Nurse (HRN) #5, she stated she asked R #4 about the bruising around her neck and wrists during her visit on 04/23/24, and R #4 reported tight hands. HRN #5 stated she notified her supervisor along with the DON on 04/23/24. She also stated she wanted to ensure the DON made an incident report. HRN #5 stated the DON said she (DON) planned on filing a report. J. A request was made to Administrator regarding investigation of the above allegations. The ADM stated she was unable to locate the Incident Report or if the five day follow-up was reported to State Agency. The facility did not provide the report to the surveyors. R #5 K. Record review of facility provided Fall Reports revealed the following: - R #5 experienced an unwitnessed fall on 02/18/2024 which resulted in an abrasion (skin damage due to scraping) with bleeding on his forehead. The resident verbalized pain to left hip. - R #5 experienced an unwitnessed fall on 03/04/2024 which resulted in scrapes (cuts or tears) on his head and bleeding in his mouth. - R #5 experienced an unwitnessed fall on 03/29/2024 which resulted in right shoulder pain, right knee pain, and limited range of motion (ROM; the extent or limit to which a part of the body can be moved around a joint or fixed point, the totality of movement) to the right shoulder. L. Record review of a Change in Condition Form for R #5, dated 03/07/24, revealed staff documented the following: - R #5 had an unwitnessed fall on 03/05/24 at 11:00 am, and indicated pain to right ankle. - At 10:00 am, the nurse was called into the resident's room by the Certified Nurse Aides (CNAs) regarding resident complaining of pain to right lower extremity (RLE; right leg). Upon assessment the nurse observed swelling, bruising, and notable deformity to right ankle. The nurse contacted the Nurse Practitioner (NP) regarding obvious deformity, and the NP was unaware of any previous falls. R #5 was sent to the emergency room , was hospitalized , and required surgery to repair broken bones. M. On 05/06/24 at 4:28 pm, during an interview with Anonymous Staff (AS), she stated R#5 on the north wing had multiple falls. She stated she knew for sure the resident's leg was fractured and his hip was broken. She stated staff did not report R #5 knee injury, for three or four days She stated another nurse found the injury and asked why the injury was not reported. The AS stated staff told her it was because the DON did not want to do a five day follow up report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #8 N. Record review of R #8 face sheet revealed she was admitted into the facility 12/27/23. O. Record review of an Abuse Questionnaire form (a facility-initiated form which asked residents about abuse, neglect and exploitation by staff in the facility), dated 04/23/24 revealed the following: - R #8 stated CNA #3 was rude to her and made her feel bad for needing anything. - R #8 stated she knew how to report abuse, neglect, or exploitation. - The abuse coordinator was the Administrator (ADM). - The staff aware of the questionnaire form were the DON, ADM, and Licensed Practical Nurse (LPN) #2. P. On 05/06/24 at 4:22 pm during interview with LPN #2, she retrieved the abuse questionnaire forms from her desk. LPN #2 confirmed R #8 completed the questionaire, and the facility did not investigate the allegation. LPN #2 stated the staff that were aware of the questionnaire forms were the DON, ADM and LPN #2. Q. Record review of the facility's Reportable Incidents Reports revealed staff did not report R #8's abuse allegations to the SSA. Further review revealed the facility did not investigate the allegations. R. On 05/06/24 at 4:45 pm during an interview with the DON, she stated staff did not report R #8's allegations to the SSA. R #9 S. Record review of R #9 face sheet revealed she was admitted into the facility 11/22/23. T. Record review of an Abuse Questionnaire, dated 04/23/24 revealed the following: - R #9 stated CNA # 3 was very rude and made her feel bad for pushing the call button. - R #9 stated knew she how to report abuse, neglect, or exploitation. - The abuse coordinator was the ADM. - The staff aware of the questionnaire form were the DON, Administrator and LPN #2. U. Record review of the facility's records revealed staff did not report R #9's abuse allegations to the SSA. Further review revealed the facility did not investigate the allegations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. On 05/06/24 at 4:28 pm during an interview with Human Resources (HR), she stated it was expected facility staff would report the allegations by R #8 and R #9 to the SSA and conducted a thorough investigation within the facility. The HR stated R #8's and R #9's abuse allegations were not reported to the SSA, and the facility did not investigate the allegations. W. On 05/09/24 at 10:00 am during an interview with the ADM, she stated she assumed the DON documented and completed an initial incident report and a five-day follow-up report to the SSA for the allegations by R #8 and R #9. The ADM confirmed there was not any documentation regarding a thorough investigation of the residents' allegations and was unable to locate the FRI and the five day follow-up. R #10 X. Record review of the facility's log of Facility Reportable Incidents Report, revealed R #10 experienced an unwitnessed fall on 03/29/24 which resulted in a bump on her forehead and the inability to move. Resident was sent to the emergency room and required a computed tomography scan (CT; an imaging test that uses x-rays and a computer to create detailed images of bones and soft tissues) of her head. Y. Review of the Facility Incident Reports (FRI) submitted to the SSA indicated the facility did report the resident's unwitnessed fall on 03/29/24 which resulted in injuries. 49827

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. 40671 Based on record review and interview, the facility failed to complete and document a thorough investigation, implement measures to prevent further abuse, and implement corrective actions regarding allegations of neglect (failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness) and abuse (knowingly causing physical or mental harm or failing to provide goods and services necessary to avoid physical or mental harm) for 3 (R #s 4, 8 and 9) of 7 (R #s 4, 5, 6, 7, 8, 9 and 10) residents reviewed for abuse/neglect allegations when staff failed to: 1. Complete and document a thorough investigation, remove staff identified while the investigation was conducted, and implement corrective actions for R #4, R #8 and R #9. 2. Provide a follow-up report within five working days from the date of the incident to the State Survey Agency (SSA) for R #4. If the facility fails to implement preventive and corrective actions necessary to prevent and correct the incident from happening again and fails to send the report to the SSA, then it is likely residents will feel frustrated, unsafe, and not enjoy living to their highest practicable well-being. The findings are: R #8 A. Record review of R #8 face sheet revealed she was admitted into the facility 12/27/23. B. Record review of an Abuse Questionnaire form (a facility-initiated form which asked residents about abuse, neglect and exploitation by staff in the facility), dated 04/23/24, revealed the following: - R #8 stated Certified Nurse Aide (CNA) #3 was rude to her and made her feel bad for needing anything. - R #8 stated she knew how to report abuse, neglect, or exploitation. - The abuse coordinator was the Administrator (ADM). - The staff aware of the questionnaire form were the DON, ADM, and Licensed Practical Nurse (LPN) #2. C. Record review of the facility's records revealed staff did not investigate R #8's abuse allegations. D. On 05/06/24 at 4:45 pm during an interview with the DON, she stated staff did not report R #8's allegations to the SSA or complete an investigation. R #9 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	E. Record review of R #9 face sheet revealed she was admitted into the facility 11/22/23. F. Record review of an Abuse Questionnaire, dated 04/23/24 revealed the following: - R #9 stated CNA # 3 was very rude and made her feel bad for pushing the call button. - R #9 stated knew she how to report abuse, neglect, or exploitation. - The abuse coordinator was the ADM. - The staff aware of the questionnaire form were the DON, ADM, and Licensed Practical Nurse (LPN) #2. G. Record review of the facility's records revealed staff did not investigate R #9's abuse allegations. H. On 05/06/24 at 4:28 pm during an interview with Human Resources (HR), she stated staff should have conducted a thorough investigation of the allegations by R #8 and R #9. HR stated staff did not report R #8's and R #9's abuse allegations to the SSA, and the facility did not investigate the allegations. I. On 05/09/24 at 10:00 am during an interview with the ADM, she stated she assumed the DON documented and completed an initial incident report and a five-day follow-up report to the SSA for the allegations by R #8 and R #9. The ADM confirmed there was not any documentation regarding a thorough investigation of the residents' allegations. J. Record review of staffing schedule for CNA #3 revealed CNA #3 was removed from the schedule following the allegations on 04/23/24. R #4 K. Cross reference to findings for R #4 identified in F600. L. Record review of the facility's incident report, dated 04/23/24, revealed the following: - R #4 had injuries of unknown origin. - The SSA received the incident report from the facility on 04/25/24. - The facility did not submit a five-day follow-up report to the SSA. M. Record review of staffing schedule for LPN #4, LPN #5, and CNA #2, revealed each staff member continued to be placed on schedule to work. LPN #5 was terminated on 05/03/24, LPN #4 was suspended 05/14/24, and CNA #2 did not have a lapse in employment. N. Record review of R #4 medical record revealed staff did not conduct an investigation related to R #4's abuse allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. Repeated requests for the facility investigation of the incident for R #4 were made to the Administrator, but the facility did not provide an investigation. Based upon observations, record reviews, and interviews, Immediate Jeopardy was identified on 05/15/24 at 2:24 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 05/15/24 at 4:43 pm. Implementation of the POR was onsite on 05/16/24 by conducting observations, record reviews, and staff interviews. The scope and severity was lowered to E. Plan of removal: A full abuse investigation will occur within the facility to ensure no other residents have witnessed abuse, or been abused, completed on 5/13/2024. If any further abuse allegations are brought forward, the facility will remove any resident from the abuse situation, and proper monitoring and interventions will be initiated immediately upon notification. There were no new allegations brought forth at that time. If any staff are identified in an allegation of abuse, they will be placed on administrative leave until the investigation is complete. On 5/15/2024 surveyor's identified an LPN [LPN #2/Unit Manager] of concern, this LPN was placed on administrative leave at that time on 5/15/2024, pending an investigation. This LPN last day worked was 5/9/2024. The Administrator resigned on 5/10/2024. The Director of Nursing was placed on administrative leave on 5/9/2024. The Interim Director of Nursing/designee re-educated current staff regarding abuse policy. The education includes the policy, with emphasis on the following: If abuse or behavioral issues are occurring (combative/physical behavior, threatening behavior, or anything that could be harmful to oneself or any other person), the victim should be separated from the aggressor immediately. The aggressor should be placed on 1:1 supervision immediately, and remain on this type of monitoring until they have been sent to the ER, a behavioral unit, or the provider has cleared them of all potential to harm themselves or others. Documentation needs to occur to reflect this monitoring, and clear discontinuation of the 1:1, and reasoning by a provider. If a staff member is accused of abuse, they should be replaced on their shift and removed from the building until police arrive (if necessary), removed from the schedule, and not put back on the schedule until an investigation is completed, and they have been cleared by the Administrator or DON to return. The provider, nurse manager and family has to be notified immediately. The eInteract change in condition assessment needs to be completed filled out with all the details of what happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring and interventions need to continue to happen and be documented if the resident remains in the building, until we know they have stabilized per the provider, or have left the center. The Interim Director of Nursing/designee will begin education 05/15/24 and continue until all staff have been educated prior to their next shift, any licensed staff member on leave of absence (FMLA), vacation, or PRN staff will be re-educated prior to returning to duty. New hires/agency staff are educated on the abuse policy and process during orientation 49827 48960

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 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 #3) of 2 (R #3 and #5) residents when they failed to follow through with physician's orders to place a peripherally inserted central catheter (PICC; a long thin tube that is inserted through a vein in your arm and passed through to the larger veins near your heart) line to administer intravenous (IV) antibiotic treatment and to order and apply a wound vacuum [a medical device that uses negative pressure (suction) to help bring the edges of your wound together. It also removes fluid and dead tissue from the wound area and aids in healing] for R #3. This deficient practice likely resulted in the resident experiencing medical complications or a worsened condition. The findings are: A. Record review of R #3's face sheet revealed an initial admitted [DATE] with the following diagnoses: - Acute osteomyelitis (infection in the bone) left ankle and foot, - Cellulitis (a serious bacterial infection of the skin which usually affects the leg, and the skin appears as swollen and red and painful), - Acute kidney failure. B. Record review of R #3's nursing progress note, dated 06/13/23, revealed she was admitted to the facility for wound care infection and had wound dressings to left buttock, anterior (front side) thigh, and bilateral (both) lower extremities (legs). C. Record review of R #3's Wound Care Clinic progress report, dated 09/08/23, revealed R #3 received treatment for the following wounds: - Ischemic ulcer (wound that develops when the arteries do not deliver enough blood flow to specific area) to the left calcaneal (largest bone in the foot) region, which measured 6.5 x 4.5 x 1 centimeters (cm). - Venous ulceration (wounds that are caused by poor blood circulation) to the left medial (middle) lower extremity, which measured 4.7 x 3.5 x 0.3 cm. - Venous ulceration to the left anterior lower extremity, which measured 0.6 x 0.4 x 0.3 cm. - Ischemic ulcer to the right calcaneal region, which measured 3.2 x 3.6 x 1.3 cm. - Venous ulceration to the right anterior ankle, which measured 0.3 x 1 x 0.2 cm. - Non-healing wound to the right lower abdomen, which measured 0.5 x 1 x 0.2 cm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	- Resident was placed on oral antibiotics pending wound culture results. D. Record review of R #3's Physician's Orders revealed the following: - An order, dated 09/29/23, for a wound vacuum per physician. Call for specific orders. - An order, dated 09/29/23, for a PICC line to be placed per physician. Start date: 09/29/23. End date: 10/10/23. E. Record review of R #3's Wound Care Clinic progress report, dated 09/29/23, revealed the following: - Physician called and spoke with the Director of Nursing (DON) at the care facility. The DON stated she ordered a PICC line for R #3, but the local hospital would not do the PICC line due to R #3 could not transfer herself and would not stay still for an hour. - Facility to order and administer the following medications: - Ciprofloxacin (medication used to treat infections), 500 milligrams (mg) orally twice a day for 14 days. Start 9/29/23, End 10/13/23; - Linezolid (medication used to treat infections), 600 mg orally, twice a day for 14 days. Start 9/29/23, End 10/13/23. - Facility to insert PICC line and administer intravenous (IV; a medical procedure that delivers fluids, medications, and nutrients directly into a person's vein) antibiotics (ABX; drugs that treat bacterial infections) as previously discussed with physician. - A wound vacuum will need to be ordered by facility. Send the machine and dressing changes with patient to next appointment. F. Record review of R #3's nursing note, dated 09/29/23, revealed staff documented the following: - At 1:30 pm: Received call from physician. Wants PICC line set up and placed. Will send culture (cx; a lab test to determine if infection is present in blood, skin tissue, or other substances found in or on the body). Wants physician or Nurse Practitioner (NP) to prescribe intravenous antibiotics (IV ABT). - At 2:00 pm: Wound Clinic unable to place PICC line. Called and spoke with charge nurse. Must go through Infusion Center. - At 2:25 pm: Returned call to physician to inform of complications. Office closed. - At 5:30 pm: Received culture from provider. Placed in NP box for review. G. Record review of a handwritten note, located in the DON's office, dated 09/29/23 and written by the DON, revealed staff received a call from the wound clinic physician with orders for a PICC line insertion for R #3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	H. Record review of R #3's Physician's Orders revealed the following: - An order, dated 10/03/23, for a complete blood count (CBC; blood test that measures our blood cells in the blood stream), comprehensive metabolic panel (CMP; comprehensive metabolic panel blood test that measures specific elements found in the blood stream), prothrombin time test/ international normalized ratio [PT/INR; a blood test used to monitor warfarin (blood thinner) treatment and measures how long it takes for a clot to form in your blood] to be drawn for PICC line placement. One time only. Start date: 10/03/23. End date: 10/05/23. - An order, dated 10/04/23, for wound vacuum. Apply cutercin (type of wound dressing) then wound vacuum with setting at medium and/or 125 pressure to each heel. Send wound vacuum supplies with patient to wound care appointment on 10/06/23. Wound vacuum initial change will be completed by wound care specialist. Start date: 10/04/23. I. Record review of R #3's Wound Care Clinic progress report, dated 10/06/23, revealed R #3 had a significant wound culture with multidrug resistance (MDRO, a germ that is resistant to many antibiotics). Resident required IV antibiotics, which were ordered two weeks ago. Resident still cannot get a PICC line. Concerned R #3 may have progressed to a deeper space infection without initiation of IV antibiotics. Will send to hospital emergency department for admission. J. Record review of R #3's Physician Progress notes revealed the writer documented the following: - On 10/03/23 at 11:00 pm, spoke with daughter at resident's bedside about her concerns regarding wound care management of bilateral lower extremities. Daughter inquired about wound care specialist recommendation of PICC line placement and IV antibiotic, along with wound vacuum application. The writer called physician's office at 12:30 pm and spoke with a Registered Nurse (RN). The RN reported that patient needed PICC line for diagnosis of osteomyelitis and antibiotic therapy (ABT). Patient currently on two oral antibiotics, because patient did not have an established PICC line at this time. RN okay with linezolid by mouth (PO) and Cipro (an antibiotic) PO, that was previously ordered by physician. Per conversation with RN, she would like facility to place wound vacuum today to bilateral heels and to send wound care supplies to upcoming appointment on Friday. The physician's office will perform initial change. Discussed conversation with patient's daughter, nursing staff, and DON regarding plan of care. - On 10/06/23, the patient was sent to emergency room (ER). Facility to order and administer the following medications: - Ciprofloxacin, 500 mg, PO twice a day (BID) for 14 days. Start 09/29/23. End 10/13/23; and - Linezolid, 600 mg, PO BID for 14 days. Start 09/29/23. End 10/13/23. - Facility to insert PICC line and administer IV antibiotics as previously discussed with physician. - Again, a wound vacuum will need to be ordered by facility. Please send the machine and dressing changes with patient to next appointment. K. Record review of R #3's Nursing Notes, dated 10/2023, revealed staff documented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	- On 10/02/23, Called infusion center. Able to schedule. Must have labs, order for antibiotic therapy of choice. Culture in NP box for review. Request order for labs and prescription (Rx) from NP. Patient scheduled for appointment with physician. Rescheduled for 10/03/23 per daughter. - On 10/03/23, staff documented the following: - Transportation aid contacted at appointment. Spoke to physician. Facility unable to get PICC. Sent back on oral antibiotics (PO ABT). - NP called physician's office. Continue PO at this time. - Stopped PICC line process. - Appointment with physician. Wound vacuum sent. - On 10/06/23, resident had an appointment with physician. Resident sent to ER and admitted . The daughter rescheduled appointment on 10/09/23, because she did not want R #3 riding with anyone in van. L. Record review of R #3's hospital records, dated 10/6/23 through 10/14/23, revealed the following: - Diagnoses: decreased circulation, ischemic ulcer of left heel with necrosis (the death of cells in body tissue) of muscle, high blood pressure, ischemic ulcer of right heel with necrosis of muscle, cellulitis of both lower extremities. - Infections: Methicillin-resistant staphylococcus aureus (MRSA; a type of drug-resistant staph infection and can cause infections in the skin, lungs, or other organs.) Onset 09/09/23. - Next Wound Care appointment for 10/20/23. - Discharge instructions: Start the following: - Metronidazole (Flagyl; antibiotic), 500 mg total, one tablet PO three times a day. - Vancomycin (antibiotic), infuse 1000 mg into a venous catheter one time each day at the same time. - Water for injection solution 20 ml with ceftriaxone (antibiotic) 2 gram. Infuse 2 g into venous catheter one time each day at the same time. M. Record review of R #3's Physician's Orders revealed the following: - An order, dated 10/14/23, for central vascular access service (CVAD; device inserted into the body through a vein to enable the administration of fluids, blood products, medications and other therapies into the bloodstream). IV medications for wound infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	- An order, dated 10/14/23, for ciprofloxacin HCl oral tablet, 500 mg. Give 500 mg PO twice a day. Start date 10/14/23. End date: 10/16/23. - An order, dated 10/14/23, for vancomycin HCl (antibiotic medication) IV solution, 1000 mg/200 ml. Use 1000 mg intravenously. Start date: 10/14/23. End date: 10/19/23. - An order, dated 10/17/23, for ciprofloxacin HCl oral tablet, 500 mg. Give 500 mg by mouth. Start date: 10/17/23. End date: 10/21/23. - An order, dated 10/19/23, for vancomycin HCl intravenous solution, 1000 mg/200 ml. Use 500 mg intravenously. Start date: 10/19/23. End date: 10/21/23. - An order, dated 10/19/23: If resident begins to decline, to include but not limited to abnormal vs. worsening mentation (term used to describe the process of thinking or reasoning), abnormal labs (kidney function specifically) call provider agency's on-call physician or physician as soon as possible. High-risk patient. Every day and every night shift. Start date: 10/19/23. End date: 10/21/23. N. Record review of R #3's Wound Care Clinic progress report, dated 10/20/23, revealed the following: - R #3 was admitted to the hospital from 10/6/23 until 10/14/23. She was treated for osteomyelitis to bilateral heels. She was discharged on IV Rocephin (medication used to treat infections), IV vancomycin; oral Flagyl (medication used to treat infections), and oral ciprofloxacin. - R #3 had new neurologic concerns. She was somnolent (sleepy, drowsy), had decreased responsiveness and slurred speech. - R #3 sent to hospital emergency room . - A wound vacuum will need to be ordered by facility. Please send the machine placed on patient for next appointment. - Run wound vacuum continuously at 150 mmHg (measurement of amount of pressure applied.) O. Record review of R #3's Physician Progress note, dated 10/20/23, revealed the writer documented the facility was to manage IV antibiotics. Patient may follow up with infectious disease physician. Again, a wound vacuum will need to be ordered by facility. Please send the machine placed on patient for next appointment. P. Record review of R #3's nursing notes revealed staff documented the following: - On 10/14/23, the resident returned to the facility and midline (a long thin, flexible tube that is inserted into a vein in the upper arm and is shorter in length then a PICC line) was placed. - On 10/20/23, the resident went to wound care appointment on 10/20/23 and was sent to the ER. Q. Record review of R #3's discharge Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/20/23, revealed the resident discharged to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	R. Record review of NP email communication with facility, dated 11/22/23, revealed the following: - The NP became aware of new documents uploaded to R #3's profile. - The NP felt a document uploaded on 11/07/23 was alarming. It was a handwritten 'timeline of events'. The problem: The NP was mentioned multiple times as being notified or results placed in NP box between 09/29/23 and 10/02/23. - The NP disputed the following documentation: - On 09/29/23 at 1:30 pm, staff documented the physician wanted the NP to prescribe antibiotics based on the R #3's culture results, but the NP stated she was not made aware. The NP stated R #3 was already being treated with PO antibiotics by physician when she saw the resident. The NP stated the document also contradicted the note made by nursing staff on 09/29/23, which stated the staff attempted to contact the physician at 7:00 pm for IV antibiotic clarity, but the office was closed. Staff made the DON aware that orders were vague. The NP stated the staff statement did not state the NP or the physician was to manage IV antibiotics, and this was consistent with her earlier emails about the DON's poor communication. - On 09/29/23 at 5:30 pm, staff documented they obtained cultures from (name of facility) and deposited in the NP's box for evaluation. The NP stated that was incorrect. She stated the Unit Manager/LPN #2 supplied the sole document she received regarding cultures or labs on 10/03/23. The NP stated the results showed findings that were specifically sent to the DON on 09/15/23 and were not included in R #3's profile or placed in the NP's box. - On 10/02/23, staff documented a request for labs, antibiotics of choice, and culture in NP box for review was communicated to NP, but the NP stated that was incorrect. She stated she received the culture results via email on 10/03/23 and saw the patient on 10/04/23. - On 10/03/23, staff documented they stopped the PICC line process, but the NP stated that was incorrect, and the resident still required a PICC line. The NP stated RN #2 booked a PICC line placement after the NP requested that she look into PICC line insertion at [name of facility]. The NP stated staff documented a wound vacuum was provided on 10/03/23, which was also untrue. The NP stated she had the nursing staff and Minimum Data Set Coordinator (MDSC) try to get a second wound vacuum as soon as possible, because the facility only had one wound vacuum in the house. The NP stated R #3 required two wound vacuums for her upcoming appointment on 10/06/23 per the discussion with the Wound Care Clinic. The NP stated R #3 had yet to attend the Wound Care Clinic appointments with the requested supplies per the wound care nurse. The NP also stated it was worth noting that R #3's daughter did not reschedule the patient's appointment for 10/05/23 because she did not want anyone riding in the van with the resident. She stated it was a scheduling conflict. She stated the daughter did not want R #3 sitting in the city from early morning for an afternoon appointment, because the resident would miss lunch and no one would be available to assist with incontinence, or patient needs, etc. - The NP requested the document be corrected to reflect factual events. S. On 11/7/23 at 11:30 am during an interview, R #3's daughter stated R #3 did not have the PICC line or the wound vacuum in place for over a month. The daughter stated she felt the facility failed to properly carry out the orders from the wound care physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	T. On 05/08/24 at 2:07 pm during an interview, RN #2 stated R #3 had an order for a PICC line for antibiotics, but that was not done. RN #2 stated the DON told her that R #3 was supposed to have a PICC line for IV antibiotics. She said the DON stated, What do we do? RN #2 stated she contacted the hospital to see if they could get R #3 in for an appointment to get a PICC line done. She stated the hospital told her the resident had to get certain labs done prior to getting the PICC line put in. RN #2 stated she relayed the information to the DON, but it was not done. RN #2 stated R #3 ended up being sent from the wound clinic to the hospital. U. On 05/09/24 at 2:02 pm during an interview, Licensed Practical Nurse (LPN) #6 stated she worked on the floor when R #3 was a resident. LPN #6 stated the resident had wounds on her lower extremities and went to the Wound Care Center. LPN #6 stated, after one appointment at the wound clinic, the transportation driver came in late with R #3, and he gave her (LPN #6) papers for the DON. LPN #6 stated she told the transportation driver that she was not the nurse on the resident's side of the facility, but she would give the papers to RN #1, who was R #3's nurse. LPN #6 stated the transportation driver said, Ok, but [name of DON] told me not to give them to anyone except her (DON). LPN #6 stated she told him the DON was already gone, and her office door was shut. LPN #6 stated the transportation driver responded, I know but [name of DON] told me to just give them to her. LPN #6 stated she looked at the papers from the wound clinic, and there were orders for IV antibiotics and wound vacuums for R #3. LPN #6 stated she called the DON and told her about the new orders to have an IV placed, for IV antibiotics, for a wound vacuum, and for the wound vacuum to be sent with R #3 to her next appointment at the wound clinic. LPN #6 stated she was in the office about a month later, and the DON said, I totally forgot that [name of physician] wanted an IV put in for R #3 for IV antibiotics for her legs. LPN #6 stated the DON asked her if maybe RN #2 could get one of her friends at the hospital to get R #3 in right away to get a central line (a long, flexible tube inserted into a vein that leads to your heart) put in. LPN #6 stated RN #2 called the hospital and tried to get R #3 in for an appointment at 3:00 pm or 4:00 pm on a Friday afternoon, but the hospital could not get R #3 in. LPN #6 stated that about two to three weeks after the transportation driver gave her the orders from the wound clinic, R #3 went back to the wound care doctor for a follow-up. LPN #6 stated the wound clinic ordered again for the IV to be placed for R #3 to receive IV antibiotics. LPN #6 stated R #3 ended up being admitted to the hospital, and the resident passed away. LPN #6 stated the DON said she (LPN #6) never called her (the DON) about the order, and the DON said the order did not exist. LPN #6 stated she reported to RN #8 the order existed, and she (LPN #6) spoke the DON and gave her the information. LPN #6 stated R #3's family member called and asked about the order. She stated she told the the family member she saw the order and gave it to the DON. LPN #6 stated the orders were never uploaded into R #3's medical record, and the paper copy of the order disappeared. V. On 05/09/24 at 10:00 am and 4:00 pm during interviews, the Administrator stated she was not aware the DON withheld orders or medication for R #3. W. On 05/09/24 at 7:09 pm during an interview, RN #1 stated R #3 had wounds to both feet, and the resident was sent out multiple times due to the wounds being infected. RN #1 stated the resident went to a follow-up appointment with her wound care physician and was admitted to the hospital due to the infections. She stated two to three weeks prior to R #3 being hospitalized , the facility received an order for a PICC line, but it was never done. She stated the DON was responsible for R #3's orders, and the resident's medical record contained documentation of multiple requests for the PICC line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0684 Level of Harm - Actual harm Residents Affected - Some	X. On 05/14/24 at 11:32 am during an interview, the Anonymous Staff (AS) stated the DON never communicated wound care orders to the other healthcare providers in the facility. She stated R #3's electronic health record did not contain any notes regarding the DON's conversation with the wound care physician, and the hand written note was not available for other healthcare providers to read. Y. On 05/22/24 at 1:41 pm during an interview with the Medical Doctor (MD) from the Wound Care Clinic that provided care for R #3, he stated he believed R #3's wounds became worse because they were not treated according to his orders. He stated the PICC line and IV antibiotics were never started at the time he placed the order, and those could have likely have prevented the infection from becoming worse. He stated the failure to start those may have likely also affected R #3's wounds ability to improve. The MD stated R #3 had necrotic tissue, bone exposure, and an infection which was confirmed by lab samples of wound tissue and bone scan of the affected areas. 34439

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40671 Based on record review and interview, the facility failed to ensure nursing staff demonstrated appropriate competency and skills when: 1) LPN #2/Unit Manager failed to administer accurate medication dosages to a resident; 2) LPN #2 failed to follow facility process for receiving emergency medications; 3) LPN #2 inaccurately documented on the medication administration record to intentionally deceive; 4) LPN #1 began working without completing an application, having a background clearance, training and demonstration of competency prior to providing care to residents. This deficient practice likely resulted in: 1) R #1 receiving too much medication, which resulted in her being admitted to the hospital on 11/06/23 for difficulty breathing and altered mental status, and 2) A non-employee nurse working, including providing direct care and administering medication to residents, for three shifts without a background clearance, TB testing, or training. The findings are: Medication Error A. Record review of facility's Management of Controlled Drugs policy, dated 08/01/05 revised 04/01/22, revealed staff to utilize the Automated Medication Dispensing Systems (AMDS) which may have an emergency supply of controlled substances. Nurses must follow federal and state regulations to access emergency supplies of controlled substances. B. Record review of facility's Medication Error policy, dated 01/01/04 revised 06/01/21, revealed staff to investigate medication errors and implement appropriate interventions. Staff will report, log, and trend medication errors. A medication error was defined as a discrepancy between what the physician/advanced practice provider ordered and what the resident/patient received. Types of errors include: medication omission; wrong patient, dose, route (oral or injected), rate, or time; incorrect preparation; and/or incorrect administration technique. C. Cross reference F760 D. Record review of the facility's documents revealed the following: - Staff did not report the overdose to the hospital; - Staff did not report the overdose to the State Agency; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The Administration did not investigate the incident; - Staff did not document the medication error. - Staff inaccurately documented that the medication had spilled. E. On 05/09/24 at 3:03 pm during an interview, the Administrator (ADM) stated the DON and LPN #2/Unit Manager did not report the medication error to her. She stated she was not aware they reported the incident to the NP or that staff documented the morphine as spilled. Not conducting background check, provide training and verify competency prior to working F. Record review of the facility's Hiring Policy, dated 07/01/22 , revealed offers of employment were contingent upon successful completion of hiring requirements, including verifying credentials, licenses, and/or other documents required, completing a criminal background check, substance abuse screening, and employee health screening. G. On 05/07/2024 at 4:28 pm, during an interview with Payroll/Scheduler (PS), she stated she came into work on 05/06/24 and found a written time sheet on her desk, which was signed by LPN #2/Unit Manager and LPN #1. She stated LPN #1 was not a hired employee and did not have an application on file. The PS stated that according to the time sheet, LPN #1 worked in the facility from 05/03/24 thru 05/05/24. She stated LPN #2 told LPN #1 to work over the weekend in place of LPN #5, and LPN #1 used LPN #2's credentials to log into the system [electronic medication record] over the entire weekend. The PS stated she notified the Administrator on 05/06/24 and was told to just get her hired. The PS stated she also notified the Corporate Human Resources (CHR) as was told to just hurry and get LPN #1 hired. H. Review of the nursing schedule, dated May 2024, revealed the schedule did not include LPN #1. Further review revealed LPN #5 was scheduled to work 05/03/24 through 05/05/24. I. Review of the written time sheet revealed LPN #1 worked 05/03/24 through 05/05/24, and she signed the time sheet. Further review revealed the time sheet was also signed by LPN #2, the Unit Manager. J. Record review of LPN #1's application revealed it was submitted on 05/06/24. The records did not contain documentation prior to 05/06/24 that LPN #1 received background clearance, training and demonstration of competency. K. On 05/09/24 at 4:00 pm during and interview with ADM, she stated she told PS to hire LPN #1 on 05/01/24 and the PS forwarded on to the corporate human resource person. The ADM stated she did not know LPN #1 worked in the building 05/03/24 through 05/05/24. She stated the PS told her about LPN #1 on 05/06/24. Based upon record review and interviews, Immediate Jeopardy was identified on 05/09/24 at 1:08 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 05/10/24 at 2:02 pm. Implementation of the POR was onsite on 05/16/24 by conducting observations, record reviews, and staff interviews. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan of removal: Effective immediately May 9, 2024, a full audit of all current staff working in the center will occur by the end of the day on May 14, 2024, to ensure the proper hiring process was completed, including screening and training, with emphasis on: background checks, finger prints, Electronic Health Record (EHR) access. Anyone identified as not meeting these requirements will immediately be removed from the schedule until requirements are met. A full audit of current direct care staff will occur by the end of the day on May 14, 2024, to ensure all direct care staff have their own EHR access. Market Human Resources/designee will re-educate current management staff on hiring process, including required screening and training prior (background checks, finger prints and EHR access) to beginning work within the center. Nurse manager/designee will provide education to all staff that they are never to use another staff member's sign-in for any application. If they are unable to use their own sign-in, they will contact IT and/or management immediately until their access issues have been resolved. Education will begin 05/09/24 and continue until all identified staff have been educated prior to their next shift. Any management staff member on leave of any type, 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 Administrator/designee will review new hires daily to ensure the process for new hires is being followed. The Director of Nursing/designee will begin education 5/9/2024. As of the end of the day, 5/10/24, 100% of currently scheduled staff will have been educated on this information. Any staff member that is not on the current schedule as of 5/10/2024, is on leave of any type, or PRN staff will be educated prior to returning to their next shift. New hires/agency staff will be educated during orientation. 49827

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to ensure residents were free of significant medication errors for 1 (R #1) of 1 (R #1) residents reviewed for neglect, when nursing staff administered the wrong dose of medication to R #1. This deficient practice likely resulted in the overdosing of R #1 which resulted in an immediate increased in heart rate, decrease in blood pressure, inability to respond and fatigue requiring admission to the hospital. The findings are: A. Record review of R #1's Face Sheet revealed an initial admitted [DATE] and a discharge date of [DATE]. B. Record review of R #1's Physician's Progress notes, dated 11/06/23, revealed the physician saw the resident for altered mental status (change in normal mental function), tachycardia (faster than normal heart rate), low blood pressure, and hypoxia (low levels of oxygen in blood). A Certified Nursing Assistant (CNA) called the writer to the shower room around 10:30 am, because resident was acting differently. The writer took the resident to the nursing station and obtained the resident's vital signs (the basic functions of your body). The vital signs were as follows: oxygen 82 percent (%) room air (without the use of supplemental oxygen) , heart rate 154 beats per minute (bpm; normal heart rate for a female whose age is [AGE] years old is between 71 and 73 bpm), blood pressure unable to obtain. The resident did not appear to respond to the writer's voice, as the resident's baseline (normal state of being) was eye tracking (following with your eyes) with some verbal statements. The writer called the Registered Nurse (RN) and the Unit Manager to assist with the resident. The nursing staff reported the resident did not eat any breakfast and had loose stools throughout the weekend. The writer noted the resident had cracked, dry lips and dry oral membranes. Staff placed the resident in her room with intravenous (IV) started, normal saline infused, 500 milliliters (ml) bolus (single large dose of medication), and supplemental oxygen in place at 6 liters (L) via simple mask (a device that covers the nose and mouth and delivers oxygen to patients). Verbal order: 2 mg morphine oral concentrate one time, now. At 10:45 am, the writer attempted to call the resident's emergency contact. The daughter agreed with current interventions and agreed for resident to be transferred to the hospital for all life-saving interventions, if necessary. At 11:25 am, the resident's vitals were as follows: blood sugar 134 (normal range is 80-180), blood pressure 101/63 (normal range for an [AGE] year old female is 139/68), heart rate 117 bpm, and oxygen 98% on 6 L. The writer noted the resident's mentation (mental activity) was still altered from baseline. At 11:36 am, the resident was transferred to hospital via Emergency Medical Services (EMS). C. Record review of R #1's Physician's Order, dated 11/06/23, revealed an order for morphine sulfate concentrate (medication used to treat pain), oral solution, 20 milligram/milliliter (mg/mL). Give 2 mg orally immediately (STAT) for pain. [This was a one time order during an emergent situation.] D. Record review of Narcotic Tracking sheet for R #2 [morphine was borrowed from this resident to administer to R #1] revealed that on 11/06/23 there was a line through four doses of the morphine. Further review revealed staff documented the medication as spilled, and the Director of Nursing (DON) and LPN #2/Unit Manager signed the sheet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. On 05/07/24 at 5:31 pm and 05/09/24 at 11:55 am during interviews, RN #1 stated that on 11/06/23, LPN #2/Unit Manager approached RN #1's medication cart and stated she was looking for morphine for an emergency situation. She stated that R #1 was having difficulty breathing. RN #2 stated the medical provider was in the building, and she assessed R #1. She stated the provider ordered 2 milligrams of morphine for R #1 to help the resident relax and to help her breathing. RN #1 stated LPN #2 told her the NP ordered morphine for R #1, but R #1 did not have a prescription for morphine. RN #1 stated LPN #2 retrieved a bottle of morphine belonging to R #2 from RN #1's medication cart. She stated LPN #2 was shaking, so RN #1 held the bottle of morphine while LPN #2 withdrew the medication with a syringe and administered the medication to R #1. She stated she was not aware of the NP's order, because the NP gave it directly to LPN #2. RN #1 stated LPN #2 kept saying, Do you know if it was 2 milligrams or 2 milliliters? RN #1 stated that after LPN #2 administered the morphine to the resident, R #1 became less responsive, and staff called the Emergency Medical Service (EMS) to take R #1 to the hospital. RN #2 stated after the resident left, staff informed her (RN #2) that LPN #2 made a mistake and administered 40 milligrams [2 ml] of morphine to R #1 instead of 2 milligrams. She stated she immediately told the DON that amount could just shut down a person's system (cause them to become unresponsive). She stated the DON told her not to worry about it, and she (DON) would call the emergency room (ER) to report the error. RN #1 stated she noticed later it was documented on R #2's narcotic medication tracking sheet, dated 11/6/23, that 40 milligrams of morphine was spilled. RN #1 stated she did not see R #2's morphine spilled. She stated that it would have been difficult to spill the morphine due to the type of bottle the medication was in. RN #1 stated that particular bottle came with a rubber stopper (small rubber-like device that provides a secure seal and protects medication from being contaminated or spilled), and she had to hold the bottle upside down while LPN #2 withdrew the medication. RN #1 also stated the morphine orders come with specific syringes that are designed to administer a specific dosage, but LPN #2 did not use the syringe that was specific to that particular prescription. RN #1 stated LPN #2 retrieved a different syringe from the medication room. RN #1 stated the normal process for retrieving emergency medications was for staff to get the order, contact the pharmacy, and then retrieve the ordered medication from the Omnicell (automated medication dispensing cabinet) or from the E-kit (Emergency kit). RN #1 stated LPN #2 asked her if she (RN #1) wanted to sign for or administer the morphine to R #1, and she told LPN #2 no. RN #1 stated she did not receive the order and borrowing medication from another resident was not right. She stated there were different concentrations for morphine, and she did not know if the order for R #1 was the same concentration as the medication borrowed from the other resident. She stated it was important to always check if its the right medication, right dose, right patient, and right route. F. On 05/08/24 at 10:00 am during an interview, Nurse Practitioner (NP) stated she ordered 2 mg of morphine to be administered to R #1 on 11/06/23. She stated LPN #2/Unit Manager and the DON reported to her that LPN #2 administered 40 mg [2 mL] of morphine to R #1. The NP stated she immediately told LPN #2 and the DON to call the hospital emergency room and report this medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G. On 05/08/24 at 2:07 pm during an interview, RN #2 stated R #1 came out of the shower room on 11/06/23, and she was not feeling well. RN #2 stated the resident's oxygen level was low, she was breathing heavily, her blood pressure was low, and her heart rate was high. She stated the resident had difficulty breathing. RN #2 stated the medical provider was in the building, and she assessed R #1. She stated the provider ordered 2 milligrams of morphine for R #1 to help the resident relax and to help her breathing. She stated that after LPN #2 administered the morphine to the resident, R #1 became less responsive, and staff called the Emergency Medical Service (EMS) to take R #1 to the hospital. RN #2 stated after the resident left, staff informed her (RN #2) that LPN #2 made a mistake and administered 40 milligrams [2 ml] of morphine to R #1 instead of 2 milligrams. She stated she immediately told the DON that amount could just shut down a person's system (cause them to become unresponsive). She stated the DON told her not to worry about it, and she (DON) would call the emergency room (ER) to report the error. H. Record review of R #1's Medication Administration Record (MAR), dated November 1, 2023 through November 30, 2023, revealed staff did not document morphine was administered to R #1 on 11/06/23. I. Record review of R #1's Nursing Progress Notes revealed staff documented the following: - On 11/06/23 at 11:21 am, received a new order from the Nurse Practitioner (NP) to send resident to the emergency room (ER) for evaluation and treatment, as indicated. - On 11/06/23 at 12:56 pm, the EMT's arrived to transport resident to the ER. The resident received morphine sulfate (MSO4; pain medication) per NP orders. The resident's blood pressure fluctuated as well as heart rate. The resident departed to facility at approximately 11:05 am. - On 11/07/23 at 1:18 pm, the nurse called the hospital at 12:24 pm. The patient's account was password protected. At 12:45 pm [Name of] Power of Attorney (POA - person responsible for making decisions on behalf of another person) returned call and verbalized the resident had abnormal heart rate, dehydrated, UTI (Urinary tract infection - infection in any part of the urinary system), bladder infection, oxygen saturation up and down, as well as a fracture to right collarbone which appeared to either be unhealed or refractured. - On 11/08/23 at 3:46 pm, the facility nurse spoke to the Registered Nurse (RN) at the hospital's Intensive Care Unit (ICU). The resident's admitting diagnoses were sepsis due to UTI; pneumonia: Hypoxic (low level of oxygen in blood) due to pneumonia; bladder infection; acute renal failure (when your kidneys become unable to filter waste products from your blood); Atrial fibrillation (AFib; irregular heartbeat) with RVR (very rapid heart rhythm). J. Record review of R #1's hospital records revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Admission record, dated 11/06/23, the resident was admitted with the chief complaints of mental status and shortness of breath. The resident had a medical history of high blood pressure, arthritis (swelling and tenderness of joints), chronic obstructive pulmonary disease (COPD; lung disease), asthma (narrowing of the airways), and anxiety (mental disorder that causes persistent worry and fear). The patient lived at a retirement home, and staff noted the resident had more trouble breathing. Staff called EMS, who arrived and found the resident's blood pressure was 90/50. Staff reported the resident did not have any trauma to the body. Patient arrived in the emergency department (ED) initially alert but unresponsive to verbal commands. History of Present Illness: Altered Mental Status - This was a new problem. The current episode started 6 to 12 hours ago. The problem has not changed since onset. Associated symptoms include confusion, somnolence (drowsiness), unresponsiveness and weakness. Review of Systems: Positive for activity change and fatigue (extreme tiredness), shortness of breath, weakness, confusion, and tachycardia (faster than normal heart rate). - Discharge summary, dated 11/14/24, the resident passed away. Discharge diagnosis and principal cause of death was aspiration pneumonia (lung infection caused by inhaling substances like food, liquid, or vomit.) K. Record review of R #1's medical record revealed the records did not contain evidence the facility staff notified the hospital ER that staff administered 40 mg of morphine to R #1. Based upon observations and interviews, Immediate Jeopardy was identified on 05/09/24 at 5:15 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 05/10/24 at 2:02 pm. Implementation of the POR was verified onsite on 05/16/24 by conducting observations, record reviews, and staff interviews. Scope and severity was lowered from J to D. Plan of removal: Effective immediately May 9, 2024, an audit will be completed of every resident with a narcotic order, to ensure that all narcotics ordered are on the medication carts. If medications are missing, then the medication availability process will be followed and pulled from the Omnicell/Ekit. Effective immediately May 9, 2024, all nursing staff will be re-educated on the six rights of medication administration with an emphasis on right patient/resident and right dosage. Nurse manager/designee will provide education to all nursing staff on medication availability process. A unit manager will begin education on 05/09/24 and continue until all licensed nursing staff have been educated prior to their next shift. New hires/agency staff will be educated during orientation. A unit manager will begin education on 05/09/24. As of the end of each shift on 05/10/24, 100% of currently scheduled staff will be educated on this information. Any staff member that is not on the current schedule as of 05/10/24 will be educated prior to returning to their next shift. New hires/agency staff will be educated during orientation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/designee will begin education on 05/10/24. As of the end of the day, 5/11/24, 100% of currently scheduled staff will have been educated on this information. Any staff member that is not on the current schedule as of 5/11/24 will be educated prior to returning to their next shift. New hires/agency staff will be educated during orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40671 Based on record review, observation, and interview, the facility failed to:1. Ensure staff properly stored narcotic medications in a locked container. 2. Properly dispose of unused and expired medications. This deficient practice had the potential to affect all 52 residents identified on the facility census list provided by the Director of Nursing (DON) on 05/06/24. Improperly stored medications could result in a resident, staff member, or visitors taking the medications not prescribed to them. The findings are: A. On 05/06/24 at 12:42 pm, observation of the Director of Nursing's (DON) office revealed the office was unlocked, the door was open, and the office was accessible to residents, staff, and visitors. Further observation revealed various prescription bottles on the DON's desk and in an open box on the floor next to the desk. Observation also revealed piles of various bubble packs (a disposable package consisting of a clear plastic overlay affixed to a cardboard backing for protecting and displaying a product) and boxes of narcotic medications were undated and not labeled as to which resident the medications were prescribed. Medications in the DON's office included but were not limited to morphine (medication used to treat pain), fentanyl (medication used to treat pain), and various antibiotics (medications used to treat infections) B. Record review of the facility's Management of Controlled Drugs policy, dated 04/01/22 revealed the following:- Controlled substances shall not be accessible to other than licensed nursing staff, pharmacy, and medical staff (i.e., physicians, advanced practice providers) designated to the by the Center. - All controlled substances stored under double lock, separate from other medications. - Access to keys for controlled substances double locked box/cabinet for each medication cart limited to the licensed nursing staff. - Discrepancies noted at any step of the process will be reported to appropriate persons. - If a discrepancy is noted, the nursing supervisor will be notified and will immediately initiate investigation. - The Administrator (ADM) and the DON are responsible for notification of the appropriate enforcement agencies, according to state and federal regulations, of any controlled substance discrepancy which cannot be clarified satisfactorily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. On 05/06/24 at 2:00 pm during an interview, the DON stated the process for disposing of medications was for the facility to hold all medications for months, until there was enough to destroy with the pharmacist. She stated the pharmacist asked her monthly if there were any medications to be destroyed, but she frequently told the pharmacist there were not enough to destroy yet. She stated it could be months and months before there were enough medications stocked up to be destroyed. The DON stated staff should log and account for all medications before destruction. She stated all narcotics should be locked in a locked container and logged immediately by two nursing staff. The DON stated she did not log any of the narcotics in her office, because they were very busy and did not have time. The DON confirmed medications should not be on her desk and in boxes in her office. She stated all narcotics should be stored in a safe place D. On 05/08/24 at 2:07 pm during an interview, Registered Nurse (RN) #2 stated she observed random narcotics from past residents in the DON's unlocked desk drawer on 02/13/24. RN #2 stated she reported her concerns to the ADM and to the Corporate Human Resources (CHR) Director, and nothing was ever done. E. On 05/08/24 at 4:28 pm during an interview, the Payroll/Scheduler (PS) stated she recently needed some paperwork from the DON's office. She stated when she went into the DON's office she observed narcotics in the desk drawers that should have been disposed. The PS stated she felt this was concerning. She stated she took pictures of the unlocked drawers with narcotics and sent them to CHR. The PS stated nothing was done about it. F. On 05/09/24 at 12:27 pm, an observation of the Infection Control Storage room revealed several unlabeled medium- to large-sized cardboard boxes and several unlabeled plastic bins contained various medications, some dating back to 2022, to include expired or discontinued medications and medications for residents that have been discharged from the facility. Further observation revealed there were not any medication destruction logs available for the stored medications. Medications identified in the Infection Control Storage room included but were not limited to antibiotics, antipsychotics, and hypertension medications. G. Record review of the facility's medication reconciliation logs revealed the records did not contain documentation for reconciling what medications were present in the Infection Control Storage room and what medications should be there. H. On 05/09/24 at 12:32 pm during an interview, the ADM stated she was not aware there were medications stored in the Infection Control office. She further stated no one was allowed to go into that office, and only Unit Manager/Licensed Professional Nurse (LPN) #2 and the DON had the key. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I. On 05/09/24 at 2:02 pm during an interview, LPN #6 stated she shared the office with the DON while she was employed at the facility. LPN #6 stated during that time she constantly observed the DON's desk drawers unlocked and full of narcotics. She stated the facility's process for handling narcotic medications was for staff to keep them in the lock box in the nurses' medication carts, which also locked. LPN #6 stated if a resident was discharged or expired then the nurses would give the resident's narcotics and the Narcotic Count Sheet to the Unit Managers. She stated the Unit Managers would give these items to the DON. She stated she and the DON had keys to the lock box on the wall behind the DON's desk, where they kept controlled medications that were to be destroyed. She stated the lock box required two keys (LPN #6's and the DON's) to unlock the box. LPN #6 stated initially the DON would let her know when they needed to get into the lock box, but the DON stopped asking her to unlock the box after a few months. LPN #6 stated the floor nurses reported to her that they consistently observed the DON's desk drawer to be full of narcotics. She also stated the DON would tell the Pharmacist there were not any medications to be destroyed when the Pharmacist came in for medication destruction. LPN #6 stated she reported these concerns to the ADM, to HR, and to Corporate RN (CRN) #8. She stated the facility had a pharmacy inspection coming up so they were trying to get things in order. She stated there were a lot of medications that should have been destroyed months prior, there were medications in unlocked drawers, and the medication room cabinets were overflowing with medication to be destroyed. She stated there were four or five huge boxes of medications that needed to be destroyed, and the DON told her that she (the DON) hid the medications in her personal vehicle while the inspection occurred. J. On 05/09/24 at 2:48 pm during an interview, the Pharmacist stated she comes to the facility on ce a month, and her last visit was on 04/18/24. She stated she completed a non-controlled medication destruction, because the narcotics were not ready. She stated the normal process for medication destruction was staff popped the medication out of the bubble packs and into a tote. She stated the tote was then taken to the Department of Justice's office. She stated the medications that were prepared for destruction were several months worth of medications. She further stated the DON told her for several months that there were not any controlled drugs that needed to be destroyed during her (the Pharmacist's) monthly facility visits, that included medication destruction,. K. On 05/14/24 at 3:49 pm, an observation and interview revealed the East/West Medication Storage room contained various medications, in boxes and bubble packs, with no organization. Further observation revealed some medications were from 2018, and there were not any logs available to track the medications in the storage room. RN #1 stated the medications were discontinued, expired, or belonged to residents who were no longer at the facility. RN #1 also stated management had not yet reviewed or logged the medications for destruction, to the best of her knowledge. L. On 05/14/24 at 3:54 pm, an observation and interview revealed the North Hall Medication Storage room contained various medications, there were not any logs available to track the medications. LPN #3 stated these medications were discontinued, expired, were to be destroyed, or were to be returned to the pharmacy. LPN #3 stated management had not yet reviewed or logged the medications for destruction, to the best of her knowledge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	M. On 05/14/24 at 4:05 pm, an observation of the narcotic medication lock box in the DON's office revealed RN #9 held both keys and unlocked the lock box. Observation revealed there was one bottle of unopened morphine with a medication count log secured to it with a rubber band. During an interview, RN #9 stated she knew this was not the correct way to do things, because one of the keys should be held by another staff. RN #9 stated the facility called her to come in and help during the survey and gave her both keys to the lock box. Based upon observations and interviews, Immediate Jeopardy was identified on 05/10/24 at 12:56 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 05/10/24 at 3:18 pm. Implementation of the POR was onsite on 05/16/24 by conducting observations, record reviews, and staff interviews. Plan of Removal: Effective immediately, May 10, 2024, a full audit of current medications for destruction was performed on and completed by 05/11/24, to ensure all medication was accounted for, logged, secured, and locked in a medication storage area or lock box until pick-up was completed or pharmacy destruction was initiated. Effective immediately, May 10, 2024, all nursing staff was re-educated on Medication Storage Policy. The Director of Nursing/designee began education on 05/10/24. As of the end of the day, 05/11/24, 100% of currently scheduled staff have been educated on this information (Medication Storage). Any staff member that is not on the current schedule as of 05/11/24 will be educated prior to returning to their next shift. New hires/agency staff will be educated during orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 Based on interview, observation, and record review, the facility's Administrator and the Director of Nursing (Administrative Staff) failed to administer the facility when they knew/ should have known and prevented the following deficient practices which occurred in the facility: 1. Unavailability of Administrative staff causing staff to reschedule resident meetings and to be without leadership or direction. 2. Administration unavailable to report absences timely by staff members delaying ability of scheduler to find appropriate coverage. 3. LPN #1 began working without completing an application, having a background clearance, training and demonstration of competency prior to providing care to residents 4. Nursing staff changed or wrote orders without Practitioner's knowledge or consent. 5. Not reporting or investigating allegations of abuse and neglect. 6. Not ensuring staff were trained and competent before providing care to residents. 7. Not ensuring medications were safely stored and accounted for. These deficient practices were likely to affect all 55 residents identified on the resident census list provided by the Administrator and could result in residents not maintaining their highest practicable physical, mental, and social well-being. The findings are: Unavailability of Administrative Staff A. On 05/06/24 at 12:15 pm, observation and interview revealed the Administrator (ADM), the Director of Nursing (DON), and Licensed Practical Nurse (LPN) #2, who was also a Unit Manager (UM), were not in facility, and the Payroll/Scheduler (PS) called them to come into the facility. During interviews, staff who were present in the facility did not know where the ADM, DON, or LPN #2 were and did not know who was in charge during their absence. The staff stated this behavior was normal for ADM, DON and LPN #2. Observation also showed the DON arrived at approximately 1:30 pm, and the Administrator arrived at approximately 2:42 pm. B. On 05/06/24 at 4:28 pm during an interview, the Payroll/Scheduler (PS) stated that she contacted the ADM [employed since September 2023], the PS stated that the ADM said she did not plan on being in the office today [05/06/24] due to going to a marketing event. The PS stated the ADM said she would come in since the state surveyors were there, but it would take her at least two hours to get there because the ADM lives in Lubbock, Texas. The PS stated the ADM is out of the facility the majority of the time and this had been going on for awhile. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. On 05/07/24 at 8:59 am, during an interview with the Case Manager of a health insurance company, she stated she reached out to the ADM, DON, and LPN #2 for information regarding her residents on multiple occasions. She stated her phone calls and emails went unanswered by the administrative staff. She stated she was physically in the facility and was unable to find the Administrator, DON, or LPN #2 (the Unit Manager) to obtain information. The Case Manager stated her inability to obtain current and updated information on clients caused errors in reporting and potentially caused undue stress for residents. D. On 05/07/24 at 10:50 am, during an interview, the Social Worker (SS) stated the ADM was usually unavailable and kept her phone on Do Not Disturb. The SS stated the ADM's office door remained closed and locked, and even if staff knocked on her door she would not answer. She stated the DON was rarely at the facility, and staff had to call the DON into the facility, when needed. The SS stated the resident care plan meetings were often rescheduled due to the absence of LPN #2, who was also the Unit Manager (UM). The SS stated the Unit Manager was required to attend all Care Plan meetings. The SS stated the DON could attend the care plan meeting in LPN #2's absence, but the DON was rarely in the facility. The SS stated Administrator is aware of these concerns, but nothing has changed. The SS stated, In order to do my work I need them to do their work, and I fight with them [Administration] about those things all the time. E. Record review of the facility's Post Admission Patient-Family Conference (Care Plan Meeting record), provided by the SS, revealed a list of 25 residents. Further review revealed staff rescheduled 24 residents' care plan meetings, and two of the 24 listed were rescheduled twice. F. On 05/07/24 at 11:00 am during an interview, LPN #7 stated the DON, LPN #2/Unit Manager, and the ADM were rarely at the facility and were not accessible. She stated staff are not able to contact the DON, LPN #2, or the ADM when emergencies arose or for any other reason. LPN #7 stated staff have to handle whatever the situation may be on their own. She stated she reported these concerns and issues numerous times to Corporate Human Resources (CHR) as well as to the Corporate Registered Nurse (CRN) #8, and nothing ever gets resolved. G. On 05/07/24 at 4:28 pm during an interview, the PS stated staff at the facility were frustrated, because the nurse managers and the ADM were never available to their staff and the residents. She stated the nurse managers, the DON, and LPN #2 came and went as they pleased. She stated LPN #2 often said she was working from home and turned in a paper time sheet. She stated staff were frustrated and discouraged because they have reported their issues to corporate and nothing changes. The PS stated when the ADM was present in the building, she stayed in her office with her door closed. The PS stated the ADM's phone was set on Do Not Disturb, and no one could reach her. She further stated LPN #2 did not attend morning stand-up meetings (meeting with group of like-minded peers that occurred every morning to discuss resident care/concerns), care plan meetings, or clinical meetings. PS stated the facility was switching pharmacy providers and the new pharmacy representatives came to the facility to meet with them on the morning of 05/06/24, but the ADM, DON, and LPN #2 were not available for the meeting. She stated that meetings often have to be rescheduled because the management team, listed above, are often not available. H. On 05/08/24 at 2:07 pm during an interview, RN #2 stated the DON and LPN #2 were rarely at the facility. She stated they would be there for a couple of hours and then leave. RN #2 stated when there were emergencies or issues with staff or residents, the staff would have to handle situations the best they could, because they could not reach the Administrative staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I. On 05/09/24 at 4:00 pm during an interview with Administrator, she stated communication was a problem. She stated, I'll be honest with you. I'm really tired of the fact that I do not know what's going on, and nobody's telling me anything. It really upsets me. The ADM states she thought there was good communication between her and the DON. ADM states she was not made aware of a medication error that potentially led to the death of a resident. J. On 05/14/24 at 10:32 am during an interview, Corporate Human Resources Manager (CHRM) stated several staff members informed him about their concerns with the DON, ADM, and LPN #2. He stated the DON was placed on a Memorandum of Understanding (a written agreement between two or more parties) in early April 2024 which addressed all the complaints/issues that had been reported to him. He stated the Memorandum of Understanding was a 30 day corrective action plan. K. Multiple requests were made for the schedules and time sheets of the ADM, DON, and LPN #2; but the facility did not provide the documentation. Staffing / Scheduling L. On 05/07/24 at 10:47 am, during an interview with Nurses Aide (NA) #1, she stated she tried to call in sick last week for her day shift. She stated she called the DON as directed but could not reach the DON by phone. NA #1 stated she sent the DON a text message that went unanswered. She stated she called LPN #2, and after multiple attempts, she finally received a response. M. On 05/08/24 at 5:42 pm during an interview with the PS, she stated staff call-ins are not communicated with her timely, if at all. She stated she cannot fill the absence if staff do not tell her when someone was going to be out. She stated this happens frequently, and she has complained to the Administrator on multiple occasions. The PS stated nothing has been done to correct the problem. She stated, it's a very hostile work environment. They don't communicate with me honestly. They don't tell me when they're calling in. They don't tell me when people are coming in to work. They don't tell me anything. She stated she will run short staffed, because administration does not let her know of absences as soon as they know. N. On 05/08/24 at 6:30 pm, during an interview with R #11 she stated LPN #1 administered medications to her on 05/03/24, 05/04/24, and 05/05/24. The resident stated it was not LPN #2 [LPN #2 charted medications but was not in facility working]. Cross reference F726. O. On 05/08/24 at 6:45 pm, during an interview with R #12, he stated LPN #1 worked the weekend on 05/03/24, 05/04/24, and 05/05/24,. The resident stated he knew LPN #1 personally. P. On 05/08/24 at 7:00 pm during an interview with LPN #2, she stated she worked only a few hours on Sunday night (05/05/24), and she was not in the facility the remainder of the weekend. Q. On 05/08/24 at 7:30 pm, during an interview a with R #13 she stated LPN #1 was the one who administered her medications the night of 05/03/24, 05/04/24, and 05/05/24. The resident stated she knew LPN #2, and it was not her. R. Record review of the Medication Administration Records (MAR) for R #11, R #12, R #13 revealed the record documented LPN #2 administered the medications to R #11, #12, and #13, between 8:00 pm and 9:00 pm on 05/03/24, 05/04/24, and 05/05/24 during the evening shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	S. Record review of Time Clock Correction Form for LPN #2 revealed the record documented LPN #2 clocked into the facility on [DATE] at 10:18 pm and clocked out on 05/06/24 at 3:32 am. T. On 05/09/24 at 10:12 am, during an interview, the ADM stated staff made her aware on 05/06/24 that the DON and LPN #2 allowed LPN #1 to work at the facility on 05/03/24 through 05/05/24, even though LPN #1 was not an employee of the facility. The ADM stated she hired LPN #1 on 05/01/24, but she was not aware LPN #1 did not complete the hiring process prior to being allowed to provide direct care to residents. The ADM was informed by the PS that a time sheet was placed on the PS desk to pay LPN #1 for the weekend hours that she worked. The ADM stated LPN #1 turned in an application and was officially hired on 05/09/24. The ADM stated staff made her aware on 05/06/24 that LPN #2 allowed LPN #1 to use her credentials to log in to the electronic system, to provide resident care and administer medications. The ADN stated she has not had time to address the situation with the DON or LPN #2. Standard Nursing Process Q. On 05/06/24 at 4:28 pm during an interview with the PS, she stated LPN #2 will have the DON delete documentation that the other nurses entered into the medical records, and the DON will change it. She states multiple nurses have complained to her about these issues. M. On 05/08/2024 at 10:28 am, during an interview with an Nurse Practitioner (NP), she stated she complained to the facility Administrator and her own corporate boss about the DON writing orders without direction from the Providers and working outside of her scope of practice. The NP stated the DON wrote orders, changed medication orders, and ordered medication that was not necessary for the residents. The NP stated she reported this to the Administrator, but nothing was done. The NP stated she sent numerous emails to the facility Administrator and Corporate Human Resources (CHR) to express her concerns. She stated the Administrator said, I was not aware that this was going on, and the CHR told her, it seems like you two are not getting along. You will need to learn how to work together. N. Record review of an email, dated 11/22/23 at 12:49 am and sent by the NP to CHR, revealed the NP expressed issues with false orders/documentation. The NP stated in email, I would like this document to be corrected to reflect factual events. The NP stated she had many other electronic communications with concerns regarding orders she did not write or orders that were changed. The NP stated she communicated these concerns with the DON, Administrator, and CHR on multiple occasions, and the problems continue. NP provided communication for R #14 showing DON made an medication order and was changed by another nurse and the NP states that she did not order this medication and was asked to sign this order. O. On 05/08/24 at 11:25 am during an interview with RN #2, she stated there were several occasions the DON modified or deleted documentation from the residents' medical record. She also stated they [DON and LPN #2] would put in orders under the physicians that the physicians did not order, I know two of our doctors who left within a year that she was there just because of that those reasonings and unsafe environments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325077	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovis Healthcare and Rehabilitation Center	1201 North Norris 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P. On 05/09/24 at 2:02 pm during an interview with LPN #6, she stated the DON wrote orders without consulting with the providers. She stated the DON wrote telephone orders and did not transfer the order to the medical record. LPN #6 stated the DON withheld orders, and other healthcare professionals were not informed of the orders. She stated the orders were kept on the DON's desk and misplaced in the piles of paperwork that were on her desk. Q. Cross reference F684 Not reporting or investigating allegations of abuse R. Cross reference F609 S. Cross reference F609 T. cross reference F610 Competent Staffing U. Cross reference F726 V. Cross reference F760 Medication Storage W. Cross reference F761 40671