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	09/26/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interviews and records review, the facility failed to ensure resident representatives (RR) and two (R14 and R30) of two residents reviewed for transfer requirements were provided with a written transfer notice that contained all the required information. This failure had the potential to affect the residents and their RRs by not having knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of the facility's policy titled, OPS404 Discharge and Transfer, with a revision date of 11/15/22, revealed, . Process: 5. For patients transferred to a hospital: 5.1 For unplanned, acute transfers for the patient must be permitted to return to the Center. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific transfer form. 5.1 .1 Copies of notices for emergency transfers must also be sent to the Ombudsman, but they may be sent when practicable, such as in a list of patients on a monthly basis or per state requirements . 1. Review of R14's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed she was initially admitted to the facility on [DATE] with the following diagnoses: - Chronic obstructive pulmonary disease (COPD; lung disease) with (acute) exacerbation, - Type two diabetes mellitus, - Parkinsonism (refers to brain conditions that cause slowed movements, rigidity, and tremors), - Ventricular premature depolarization (VPD; a common event that occurs when the ventricles of the heart contract too early), - Transient cerebral ischemic attack (TIA; when blood flow to part of the brain stops for a brief period of time). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R14's significant change in status Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), with an Assessment Reference Date (ARD) of 06/26/24 and located in the MDS tab of the EMR, revealed R14 had a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 13 out of 15, which indicated the resident's cognition was intact. Review of R14's Nursing Note, dated 09/07/24 at 7:00 PM and located in the Progress Notes tab of the EMR, revealed, . Hospice RN notified this nurse that after speaking to Hospice physician regarding resident's current condition, he ordered for resident to be sent out to emergency room [ER] for further evaluation and follow plan of care /MOST [New Mexico Medical Orders for Scope of Treatment] form . Review of R14's Nursing Note, dated 09/07/24 at 7:25 PM, located in the Progress Notes tab of the EMR, revealed, . At approximately 7:20 PM, emergency medical services (EMS) arrived to transport resident to ER. Current vital signs blood pressure 129/65, pulse 82, respiratory rate 20, oxygen saturation 96% on 3 liters oxygen. Resident's left side of face swollen, and continues to moan and saying, 'Help, help, help.' EMS departed facility with resident at 7:25 PM . Review of R24's Progress Notes and Miscellaneous (Misc) tabs of the EMR revealed no documentation that a written transfer notice was provided to the resident and their RR at the time of the transfer to the hospital on 09/07/24. During an interview on 09/26/24 at 12:09 PM, the Social Services Director (SSD) verified that the facility notified the resident's representative by phone that the resident was being sent out and for what reasons. The SSD stated no resident representatives or Ombudsman had been provided a transfer notice when a resident was transferred to the hospital for acute care in the prior two years that she had held the SSD position. She stated she was not aware of this requirement or that it was included in the current facility policy. During an interview on 09/26/24 at 12:49 PM, the Center Executive Director (CED) stated, I didn't realize that transfer or bed hold policy notices weren't being provided to responsible parties or representatives or Ombudsman when being sent out to the ER. I know they are required and will follow up to ensure they are done in the future going forward. 11599 2. Review of R30's Admission Record, located under the Profile tab in the EMR, revealed R30 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included pneumonia, unspecified organism; acute respiratory failure with hypoxia (low levels of oxygen in the body tissue); and sepsis (a serious condition in which the body responds improperly to an infection), unspecified organism. Review of R30's Census, located under the Clinical tab in the EMR, revealed R30 was transferred to the hospital on 08/20/24 and returned to the facility on [DATE]. Review of R30's quarterly MDS, located in the EMR under the Resident Assessment Instrument (RAI) tab with an ARD of 08/28/24, revealed R30 had a BIMS score of nine out of 15 which indicated R30 was moderately cognitively impaired. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R30's Documents tab of the EMR revealed no documentation a transfer/discharge notice was provided to R30 or her RR when she was transported to the hospital on 08/20/24. During an interview on 09/26/24 at 2:46 PM with the Director of Nurses (DON) and the Administrator, the DON confirmed that the facility had failed to provide transfer/discharge notices as required. The Administrator said he was unaware that the facility was not providing transfer/discharge notices to the residents and/or their representatives.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interviews and records review, the facility failed to ensure resident representatives and two of two residents (Resident (R) 14 and R30) reviewed for transfer requirements out of a total sample of 18 were provided with written notification of the facility's bed hold policy prior to transfer to the hospital. This created a potential for the residents to experience distress or confusion related to readmission to the facility due to the facility-initiated discharge. Findings include: Review of the facility's policy titled, AR 102 Bed-Holds, with a revision date of 01/16/23, revealed, Bed hold notification is required per Federal Regulation Title 42, Chapter IV, Subchapter G, Part 483.15(d)(2)l The resident/resident representative may choose to pay to hold the bed privately if the bed hold is not covered by Medicaid, Medicare, insurance, etc. When a resident/patient (resident) is transferred out of the service location to a hospital or on therapeutic leave, the designee will provide the resident and his/her representative, if applicable, with the written Bed Hold Policy Notice & Authorization form . regardless of payer. If the resident representative is not present to receive the written notice upon transfer, the notice is delivered via e-mail, fax, or hard copy via mail . 1. Review of R14's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed she was initially admitted to the facility on [DATE] with the following diagnoses: - Chronic obstructive pulmonary disease (COPD; lung disease) with (acute) exacerbation, - Type two diabetes mellitus, - Parkinsonism (refers to brain conditions that cause slowed movements, rigidity, and tremors), - Ventricular premature depolarization (VPD; a common event that occurs when the ventricles of the heart contract too early), - Transient cerebral ischemic attack (TIA; when blood flow to part of the brain stops for a brief period of time). Review of R14's significant change in status Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), with an Assessment Reference Date (ARD) of 06/26/24 and located in the MDS tab of the EMR, revealed R14 had a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 13 out of 15, which indicated the resident's cognition was intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R14's Nursing Note, dated 09/07/24 at 7:00 PM and located in the Progress Notes tab of the EMR, revealed, . Hospice RN notified this nurse that after speaking to Hospice physician regarding resident's current condition, he ordered for resident to be sent out to emergency room (ER) for further evaluation and follow plan of care / MOST [New Mexico 'Medical Orders for Scope of Treatment] form . Review of R14's Nursing Note, dated 09/07/24 at 7:25 PM, located in the Progress Notes tab of the EMR, revealed, . At approximately 7:20 PM, emergency medical services (EMS) arrived to transport resident to ER. Current vital signs; blood pressure 129/65, pulse 82, respiratory rate 20, oxygen saturation 96% on 3 liters oxygen. Resident's left side of face swollen, and continues to moan and saying, 'Help, help, help.' EMS departed facility with resident at 7:25 PM . Review of R24's Progress Notes and Miscellaneous (Misc) tabs of the EMR revealed no documentation that the facility's bed hold policy was provided to the resident or their RR at the time of the transfer to the hospital on 09/07/24. During an interview on 09/26/24 at 12:09 PM, the Social Services Director (SSD) verified that the facility notified the resident representative by phone that the resident was being sent out and for what reasons. The SSD stated no responsible representatives or Ombudsman had been provided written notification of the facility's bed hold policy when a resident was transferred to the hospital for acute care in the prior two years that she has held the SSD position. She stated she was not aware of this requirement or that it was included in the current facility policy. During an interview on 09/26/24 at 12:49 PM, the Center Executive Director (CED) stated, I didn't realize that transfer or bed hold policy notices weren't being provided to responsible parties or representatives or Ombudsmen when being sent out to the ER. I know they are required and will follow up to ensure they are done in the future going forward. 11599 2. Review of R30's Admission Record, located under the Profile tab in the EMR, revealed R30 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included pneumonia, unspecified organism; acute respiratory failure with hypoxia (low levels of oxygen in the body tissue); and sepsis (a serious condition in which the body responds improperly to an infection), unspecified organism. Review of R30's Census, located under the Clinical tab in the EMR, revealed R30 was transferred to the hospital on 08/20/24 and returned to the facility on [DATE]. Review of R30's quarterly MDS, located in the EMR under the Resident Assessment Instrument (RAI) tab with an ARD of 08/28/24, revealed R30 had a BIMS score of nine out of 15 which indicated R30 was moderately cognitively impaired. Review of R30's Documents tab of the EMR revealed no documentation R30 was provided a bed hold notice when she was hospitalized from 08/20/24 thru 08/24/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 2:46 PM with the Director of Nurses (DON) and the Administrator, the DON confirmed that the facility had failed to provide a bed hold notice to R30. The Administrator said he was unaware that the facility was not providing bed hold notices to the residents and/or their representatives.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20402 Based on observations, record review, interviews, and review of the facility policy, the facility failed to ensure resident Care Plans were updated and revised with new goals and interventions for two residents (R30 and R41) of 18 sampled residents. The facility failed to update the Care Plan for R30 related to oxygen usage and for R41 related to falls. This failure created an increased risk for the residents' care and services to not be appropriate for the current clinical condition. Findings include: Review of the facility policy titled, Person-Centered Care Plan, revised 10/240/22, revealed, A comprehensive, individualized care plan will be . reviewed and revised after each assessment. After each assessment means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS). Care plan includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition and mental and psychosocial needs that are identified in the comprehensive assessments. The policy further indicated, . The interdisciplinary team . will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care . related to the effectiveness of the plan of care . The care plan will be reviewed and revised by the interdisciplinary team after each assessment. It also indicated, . Care plans will be . reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments . to reflect the response to care and changing needs and goals . 1. Review of R41's undated Medical Diagnosis page in R41's electronic medical record (EMR) indicated R41 was admitted to the facility on [DATE] with diagnoses including muscle weakness (generalized) and abnormalities of gait and mobility. Review of R41's Fall Investigation Report, dated 08/15/24 and provided by the Director of Nursing (DON) on 09/25/24, indicated, Incident Location: Residents room Description: Yelling is heard coming from a room on east hall . The nurse entered the room and visualized resident sitting on buttocks right beside bed. Asked resident how he fell and he reports that he was trying to get his blanket from off the second bed . VS [vital signs] taken, small red veins noted to left shoulder and small bump on left elbow, denied hitting his head . Immediate Action Taken: Assisted resident back into motorized wheelchair per his request. Injury Type: Abrasion to left rear shoulder and left antecubital [referring to front of the elbow] and reported 8 out of 10 pain to generalized rear shoulder. Review of R41's Fall Risk Evaluation, dated 09/04/24 and located under the Assessment tab in R41's EMR, indicated R41 had no falls in the past three months and was alert and oriented to person, place, and time. The fall risk evaluation indicated R41 was at risk for falls. Review of R41's discharge-return anticipated Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), located under the MDS tab of R41's EMR and with an Assessment Reference Date (ARD) of 09/10/24, revealed R41 had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 14 out of 15, indicating no cognitive impairment. The MDS further indicated that R41 had one fall with injury (except major) since admission/reentry or the prior assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R41's Care Plan, initiated on 07/24/23, indicated, Resident is at risk for falls: CVA [Cerebrovascular accident; stroke]. Further review of the care plan revealed it had not been updated with new interventions or goals after R41 sustained the fall with injury on 08/15/24. During an observation and interview on 09/23/24 at 10:00 AM, R41 was in his room sitting in an electric wheelchair. During the interview R41 stated, Yes, I have fallen here before. It was about two weeks or so ago. I fell here in my room. I was trying to transfer myself. During an interview on 09/24/24 at 4:09 PM, the Director of Nursing (DON) stated, With this current fall, he was in his room, and they found him sitting down. He was able to tell the nurse what happened. He is able to transfer himself and likes to be very independent. During an observation on 09/25/24 at 10:30 AM, R41 was observed in his electric wheelchair going around the facility. During an interview on 09/25/24 at 1:50 PM, MDS Coordinator (MDSC) 1 stated, If someone has a fall, then in our Risk Management System it will show all incidents, and you have to put an intervention in there. You have to manually go into the care plan to enter an intervention. MDSC1 stated that the person before her [referring to MDSC2] completed the last MDS on the section referring to falls. MDSC1 stated, It shows he had a fall with injury. When asked if the care plan was updated regarding the fall R41 had on 08/15/24, MDSC1 stated, Nursing does falls and interventions, and I don't see it on the care plan. I also do not see an entry on the fall care plan. During an interview on 09/25/24 at 2:12 PM, when reviewing the EMR for R41 with the DON, the DON stated, I don't believe it [R41's care plan] was updated after the fall. She stated, I don't see it was done [updated] with any new interventions. We're supposed to update the care plan after a fall, and it should have been done within 24 hours after the fall. 11599 2. Review of R30's Admission Record, located under the Profile tab in the EMR, revealed R30 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included pneumonia, unspecified organism; acute respiratory failure with hypoxia (low levels of oxygen in the body tissue); and sepsis (a serious condition in which the body responds improperly to an infection), unspecified organism. Review of R30's Census, located under the Clinical tab in the EMR, revealed R30 was transferred to the hospital on 08/20/24 and returned to the facility on [DATE]. Review of R30's entry tracking MDS, located under the RAI tab with an ARD of 08/24/24, revealed R30 was identified to receive skilled care. Review of R30'squarterly MDS, located in the EMR under the RAI tab with an ARD of 08/28/24, revealed R30 had a BIMS score of nine out of 15, which indicated R30 was moderately cognitively impaired. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R30's most recent Care Plan, revised 07/09/24 and located under the RAI tab, included R30 required assistance for all activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) and was at risk for respiratory problems, dated 10/04/23. There were no dates to note the care plan had been reviewed or revised following R30's recent stay in the hospital. Review of R30's Clinical Physician's Orders, located under the Orders tab in the EMR, revealed R30 had orders, dated 08/24/24, for physical therapy, occupational therapy, and speech therapy upon return to the facility. Neither the orders nor the specific treatment were included in R30's care plan. During an interview on 09/26/24 at 1:14 PM, the MDSC1 stated, [R30] was not out for more than 30 days, so I just listed that she returned on skilled care. I only complete the care plans for the annual MDSs. I don't attend the care plan meetings. During an interview on 09/26/24 at 2:46 PM with the DON and the Administrator, the Administrator stated MDSC1 was new to her role and was learning with the help of staff from a sister facility. The DON confirmed that the care plan should have been updated to reflect the hospitalization and therapy services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interview, record review, and policy review, the facility failed to ensure the designated resident smoking area was safe for one of 13 residents (Resident (R) 10) reviewed for smoking. The facility failed to provide a safe smoking environment by permitting non-self-extinguishing trash cans to be available for cigarette ashes and cigarette butts to be disposed of on top of trash. The failure created the potential for cigarette butts and ashes to ignite when thrown in the non-self-closing trash cans. Findings include: Review of the facility's policy titled, Smoking Policy and Procedure, revised on 05/01/24, revealed, Ashtrays made of non-combustible materials and safe design, and metal containers with self-closing covers into which ashtrays can be emptied, shall be provided in all designated smoking areas as well as at all entrances . The admitting nurse will perform a Smoking Evaluation on each patient who chooses to smoke . Patients will be re-evaluated quarterly and with a change in condition . The facility identified 13 residents who smoked or vaped on the designated smoking patio. The smoke times were posted on the door leading out to the patio as: 9:30 AM, 1:30 PM, 3:00 PM, 7:30 PM, and 11:30 PM. Review of R10's Admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: - Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following a cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) affecting left non-dominant side; - Left hand contracture (a shortening of muscles around joints causing joint stiffness and immobility); - Convulsions (seizures), unspecified. Review of R10's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), located in the EMR under the Resident Assessment Instrument (RAI) tab and with an Assessment Reference Date (ARD) of 08/07/24, revealed R10 had a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 14 out of 15, which indicated R10 was cognitively intact. Review of R10's Smoking Assessment, dated 07/23/24 and located in the EMR under the Assessments tab, noted R10 was identified to require supervised smoking due to not being able to light a cigarette. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/23/24 at 9:30 AM of the designated resident smoking area, located at the end of the north hallway, revealed one staff member in control of the smoking materials box and monitoring six residents. Observation on 09/23/24 at 4:26 PM of the designated smoking area revealed four self-closing ashtrays on three picnic tables. One of the four ashtrays was missing one half of the self-extinguishing lid. R10 was seated in her wheelchair, next to a trash can lined with a plastic trash bag, with a pink blanket covering her legs and torso. R10 did not have an ashtray near her. The pink blanket had a cigarette burn located in the torso area of the resident. A second trash can with a swinging lid, lined with a plastic trash bag, was on the smoking patio. Inside the trash can were cigarette butts, cigarette ashes, and trash. A red self-extinguishing ash can was located next to the trashcan. R10 stated, That's locked, in reference to the red ash can. During an interview on 09/23/24 at 4:30 PM, the Activity Director (AD), who was providing supervision of the residents smoking, stated, The red can is always locked. I don't know who has the key. The AD confirmed the cigarette ashes, cigarette butts, and trash were in the non-self-extinguishing trash can. During an interview on 09/23/24 at 4:42 PM, the Maintenance Director (MD) stated, The residents probably put their ashes in the trash can. What do you want me to do? The red can is locked because residents had taken butts out of the can. The key is on the nurses' key ring. Staff are supposed to get the key from them. The MD confirmed there were cigarette ashes, cigarette butts, and trash in the non-self-extinguishing trash can lined with a plastic liner. During an interview on 09/23/24 at 4:56 PM, the AD denied knowing the key to the red ash can was on the nurse's key ring or that cigarette ashes and cigarette butts were to be emptied every smoke break into the red ash can. During an interview on 09/23/24 at 5:17 PM, the Administrator stated, We will have to make sure we have self-extinguishing ashtrays and self-extinguishing ash cans to prevent an accident. During an interview on 09/25/24 at 1:30 PM, R10 stated, in response to an observation of a cigarette burn on a purple blanket she had covering herself, I don't have to wear a smoking apron, I'm not going to catch on fire! During an interview on 09/25/24 at 3:26 PM, the Administrator confirmed smoking aprons were available. The Administrator stated, R10 is not made to wear one, she usually does well with holding her cigarette. Never known to start a fire. We will continue to supervise.

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	09/26/2024

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 - Minimal harm or potential for actual harm Residents Affected - Some	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. 43353 Based on observations, staff interviews, and record review, the facility failed to ensure medication and biological refrigerator temperatures were maintained within the required range and recordings logged for three of three refrigerators in two medication rooms. This failure had the potential to result in residents being subject to unsafe or ineffective treatment or adverse effects leading to more serious illnesses. Findings include: Review of the facility's policy titled, IC401 Medication and Vaccine Refrigerator/Freezer Temperatures, with a revision date of 07/01/24, revealed, Policy: Refrigerators and freezers used to store medications and vaccines will operate within acceptable temperature range and will be checked twice a day for proper temperatures. The acceptable refrigerator temperature range for medication and vaccine storage is 36 degrees to 46 degrees Fahrenheit . Process: 1. Staff will be assigned on each unit to: 1.1 Check internal temperatures of refrigerators and freezers used to store medications and vaccines. 1.2 Document internal temperatures on the Medication/Vaccine Refrigerator Temperature Log or Medication/Vaccine Freezer Temperature Log . On 09/24/24 at 10:31 AM, an observation of medication room at nurses' station on East/West Hall was conducted with the Infection Preventionist (IP). The observation revealed the medication refrigerator contained multiple insulin pens and vaccine vials. Review of the temperature log, dated 09/16/24 through 09/30/24 and posted on the front of the refrigerator, revealed the temperature was not consistently recorded. The temperature log was less than 50% completed with temperature/initial check offs. The IP confirmed the log was not maintained. On 09/24/24 at 10:52 AM, an observation of medication room at nurses' station on North Hall was conducted with the IP . The observation revealed the medication refrigerator contained an emergency kit box of locked medications and multiple vaccine vials. Review of the temperature log, dated 09/16/24 through 09/30/24 and posted on the front of the refrigerator, revealed the temperature was not consistently logged. The temperature logs was approximately 75% completed with temperature/initial check offs. The IP confirmed the log was not maintained. On 09/24/24 at 10:31 AM, during an interview, the IP stated, The temperature logs for the refrigerators should be filled out every 12 hours. It's considered part of infection control, and I will be following up on it. I don't know why staff haven't been completing them. On 09/25/24 at 2:01 PM, during an interview, the Director of Nursing (DON) stated, I don't know why the temperature logs weren't maintained. A process will be put in place to identify and assign staff to help maintain the appropriate temperatures and logs from now since we know. I'm still putting in place several processes since I've started in this position recently.