

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Calibre Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2029 Sagecrest Ave Las Cruces, NM 88011	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47510</p> <p>Based on record review and interview the facility failed to report injuries of unknown source within two hours to the State Agency (SA) for 3 (R #8, R #9, and R #11) of 3 (R #8, R #9, and R #11) residents sampled for abuse and neglect. If the facility fails to report allegations of injuries of unknown source to the SA within two hours, then residents could likely continue to be abused or suffer serious bodily injury. The findings are:</p> <p>R #8</p> <p>A. On 08/22/24 at 10:03 AM, during an interview, R #8 said that on 06/07/24, she was being transferred from her bed to the shower chair. R #8 said that the Hoyer lift (designed to lift and transfer patients from one place to another e.g., from bed to bath, chair to stretcher) tipped over and it hit her in the head.</p> <p>B. Record review of R #8's progress note dated 06/07/24 revealed R #8 was being transferred with a lift to a shower chair when it tipped over and hit the resident on the head. The progress note revealed that the resident reported pain to her head and three small open wounds were noted to R #8's forehead and top of head. R # 8's provider ordered R #8 to be sent to the emergency room for evaluation.</p> <p>C. Record review of the incident report dated 06/08/24, revealed R #8's incident occurred on 06/07/24 and was not reported to the State Agency until 06/08/24.</p> <p>R #9</p> <p>D. On 08/22/24 at 2:22 PM, during an interview, LPN #11 said that R #9's family had come to visit, and they were changing R #9 to get him ready for bed. LPN #11 said that R #9's son-in-law came to the nurse's station and said that R #9 had marks on him. LPN #11 said she saw abrasions (a place where the surface of something, such as skin, has been rubbed away) and bruises on R #9's back, arms, and head.</p> <p>E. On 08/22/24 at 3:42 PM, during an interview with R #9's son-in-law, he said that he had visited R #9 on 06/07/24. R #9's son-in-law said that he was getting R #9 dressed for bed and he saw scratches on R #9's back, hand, and head. R #9's son-in-law said he let the nurse know.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. Record review of the facility's incident report dated 06/10/24, revealed the incident with R #9 happened on 06/08/24 and the incident was not reported to the State Agency until 06/10/24.</p> <p>R #11</p> <p>F. On 08/21/24 at 4:14 PM, during an interview, R #11 said that on 06/17/24 she was being transferred from the shower chair to her bed and that the Hoyer Lift tipped over.</p> <p>G. Record review of the incident report dated 06/21/24, revealed the incident with R #11 happened on 06/17/24 and the incident was not reported to the State Agency until 06/21/24.</p> <p>H. On 08/23/24 at 11:19 AM, during an interview, the Administrator said his expectation is the incidents with R #8, R #9, and R #11 should have been reported to the state within two hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>Based on record review and interview, the facility failed to complete a thorough investigation regarding allegations of abuse for 1 (R #9) of 3 (R #8, R #9, and R #10) residents reviewed for abuse and neglect. This failure could likely lead to residents' claims of abuse, neglect, or exploitation not being thoroughly investigated and determining the cause. The findings are:</p> <p>A. Record review of the Incident Report dated 06/08/24, revealed an allegation of abuse of R #9 was reported to the facility on [DATE] by R #9's daughter and son-in-law.</p> <p>B. Record review of the Facility 5 day Follow Up Report dated 06/12/24, sent to the state agency revealed CNA #11 was sent home pending investigation for the allegations of abuse for R #9. CNA #11 had provided care for R #9 at the time of the incident. Interviews with CNA #11 were not documented. The follow up report did not contain any documentation that R #9's family or other CNA's involved in the incident were interviewed. The Follow Up Report did not contain any documentation of the how the facility determined that the allegations were not substantiated as documented on the report.</p> <p>C. On 08/23/24 at 8:45 AM, during an interview, the DON said that she was not working at the time of the alleged allegation of abuse of R #9. The DON said that her expectation would be to remove the staff member involved from the situation, get a statement from the staff member and then the staff member would be suspended pending investigation of the allegation. The DON said that she would interview all parties involved with the incident and with knowledge of what happened.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50497</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident was assessed for risk of entrapment (state of being stuck or caught on bed rail) from bed rails for 1 (R #25) of 1 (R #25) resident reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are:</p> <p>R #25</p> <p>A. Record review of R #25's admission record revealed R #25 was admitted to the facility on [DATE].</p> <p>B. Record review of R #25's physician orders dated 07/30/24, revealed an ordered per physical therapist (PT) recommendations for a half bed rail for the left side.</p> <p>C. Record review of R #25's care plan revealed R #25 had bed rails for mobility, positioning and safety.</p> <p>D. Record review of R #25 MDS assessment dated [DATE] under section P0100, revealed the resident does not have bed rail use.</p> <p>E. On 08/23/24 at 11:38 AM, during an observation of R #25's bed, the bed had two bilateral half side rails instead of one.</p> <p>F. On 08/23/24 at 11:59 AM, during an interview with the DON, she stated R #25's bed rails were added to the care plan on 08/15/24, because they are used for mobility, a risk assessment was not completed.</p> <p>G. On 08/23/24 at 12:06 PM, during a telephone interview with the MDS specialist, she stated R #25's bed rails are not documented on the MDS assessment because they are not considered a restraint.</p>		