

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  02/20/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</b></p> <p>Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #3) of 1 (R #3) resident reviewed for baseline care plans.</p> <p>This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:</p> <p>A. Record review of R #3's Admission Record, no date, revealed R #3 was admitted into the facility on [DATE].</p> <p>B. Record review of R #3's baseline care plan dated 01/27/25 revealed the plan was created on 01/27/25 (not within 48 hours of admission).</p> <p>C. On 02/20/25 at 12:47 PM, during an interview with the MDS Nurse, he confirmed the following:</p> <ol style="list-style-type: none"> <li>1. The baseline care plan should be created upon admission by the admitting nurse.</li> <li>2. R #3's baseline care plan was created on 01/27/25.</li> <li>3. R #3's baseline care plan was not completed within 48 hours of admission.</li> </ol>

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41755</p> <p>THIS IS A REPEAT DEFICIENCY FROM 11/06/24</p> <p>Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #3) of 4 (R #1, R #2, R #3, and R #4) residents reviewed for physician's orders, when staff did not administer R #3's blood pressure medication as ordered by the physician. This deficient practice could likely lead to the resident having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication due to it not being administered. The findings are:</p> <p>A. Record review of R #3's Physician orders revealed the following:</p> <ol style="list-style-type: none"> <li>1. Order date 01/24/25: carvedilol (medication used to treat high blood pressure) 25 mg, give via percutaneous endoscopic gastrostomy (PEG tube; to surgically insert a feeding tube into a patient's stomach bypassing the mouth and esophagus) one time a day for hypertension (high blood pressure)</li> <li>2. Order date 01/24/25: hydralazine (medication used to treat high blood pressure) 50 mg, via PEG-Tube three times a day for hypertension.</li> <li>3. Order date 01/24/25: guanfacine (medication used to treat high blood pressure) 2 mg, via PEG-Tube one time a day for hypertension.</li> </ol> <p>B. Record review of R #3's Medication Administration Record (MAR) for January 2025 revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/26/25, guanfacine was not given and staff documented vitals (vital signs; blood pressure, heart rate, temperature) outside of parameters (set number range indicated by physician) for administration.</li> <li>2. On 01/26/25, hydralazine was not given and staff documented see progress notes.</li> <li>3. On 01/27/25, hydralazine was not given and staff documented see progress notes</li> <li>4. On 01/26/25, carvedilol was not given and staff documented see progress notes.</li> <li>5. On 01/27/25, carvedilol was not given and staff documented see progress notes</li> </ol> <p>C. Record review of R #3's nurse progress notes revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/26/25 staff did not document R #3's vital signs and why guanfacine was not given (see finding B. 1. ).</li> <li>2. On 01/26/25 at 11:13 AM, staff documented: hydralazine was not given due to low blood pressure.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. On 01/26/25 at 11:16 AM, staff documented: carvedilol was not given due to low blood pressure.</p> <p>4. On 01/26/25 at 1:10 PM, staff documented: hydralazine was not given due to low blood pressure.</p> <p>5. On 01/27/25 at 10:09 AM, staff documented: hydralazine was not given due to low blood pressure.</p> <p>6. On 01/27/25 at 10:09 AM, staff documented: carvedilol was not given due to low blood pressure.</p> <p>D. On 02/20/25 at 12:15 PM, during an interview, the DON confirmed the following:</p> <ol style="list-style-type: none"> <li>1. Staff did not administer R #3's blood pressure medication according to the physicians' orders.</li> <li>2. R #3's orders for carvedilol, guanfacine and hydralazine did not have parameters in place to determine whether to hold or administer the medications.</li> <li>3. The expectation was for staff to contact the physician to determine whether the medication should be held or given.</li> <li>4. The staff should also contact the physician to determine if the order needs to be updated with parameters on when to hold the medication.</li> </ol>

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47510</p> <p>Based on record review and interview, the facility failed to provide activities of daily living (ADL) assistance for 4 (R #8, R #10, R #11, and R #24) of 5 (R #8, R #10, R #11, R #24, and R #25) residents reviewed for ADL care when staff failed to:</p> <ol style="list-style-type: none"> <li>1. Assist R #8 and R #11 with toileting.</li> <li>2. Assist R #10 with ADL care.</li> <li>3. Assist R #24 with brushing his teeth and showering.</li> </ol> <p>These deficient practices caused R #8 and R #25 psychological distress, and feeling embarrassed. The findings are:</p> <p>R #8</p> <p>A. On 02/18/25 at 8:41 AM, during an interview with CNA #8, he stated on 02/16/25, in the morning, there were only two (2) CNA's working on the South Unit. CNA #8 said there was 58 residents on the South Unit that day. CNA #8 said R #8 was assisted to the bathroom by the LPN #8 and Activity Director (AD) and was left on the toilet for approximately an hour. CNA #8 said he was assisting another resident when R #8 was taken to the bathroom at 11:00 am. CNA #8 said that when he finished, he noticed R #8's call light was still on. CNA #8 said that when he went to her room at approximately 12:00 PM, R #8 was still on the toilet in her bathroom waiting for assistance.</p> <p>B. On 02/18/25 at 9:42 AM, during an interview with R #8, she said on 02/16/25, at 11:00 AM, she was assisted to the bathroom. R #8 said she is assisted with the Sara lift (a patient-assisting device that helps patients stand up and move around) and it takes two people to help her. R #8 said when she finished in the bathroom, she turned on the call light. R #8 said it was a little before 12:00 PM, before CNA #8 was able to get her off the toilet. R #8 said she was upset and crying. R #8 said she felt like no one cared. R #8 said it takes 15 minutes to an hour for her call light to be answered. R #8 said that there is usually only one CNA on her hall. R #8 said that when she needs assistance getting out of bed or to the bathroom, she has to wait longer because the CNA assigned to her hall has to find someone to help.</p> <p>C. Record review of R #8's care plan dated 08/12/24, revealed R #8 needs assistance with ADL's.</p> <p>D. Record review of R #8's Quarterly MDS dated [DATE], revealed R #8 is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting.</p> <p>E. On 02/18/25 at 2:49 PM, during an interview, AD #8 said on 02/16/25, she assisted LPN #8 transfer R #8 to the toilet. AD said she was finishing an activity with residents and was asked to assist at 11:00 AM. AD #8 said that there were only two CNA's on the South Unit and there were a lot of call lights on. AD #8 said she tries to help when she sees call lights, but she does not work the floor.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>F. On 02/19/25 at 10:50 AM, during an interview, CNA #10 said there are a lot of residents on the South Unit that are two people assist. CNA #10 said that on 02/16/25 there was only 2 CNA's and they weren't able to do showers, vital signs, or any documentation. CNA #10 said residents end up wetting themselves and have bowel movements because they can't get to them in time.</p> <p>R #10</p> <p>G. On 02/17/25 at 2:43 PM, during an interview, R #10 said she usually waits 45 minutes to get assistance. R #10 said she is a two person assist because she needs the hoyer lift (a mechanical device that helps move people with limited mobility). R #10 said there are a lot of residents on the South Unit that need the hoyer lift. R #10 said there are only 3 CNA's scheduled on the South Unit. R #10 said that sometimes there are only 2 CNA's for the entire unit. R #10 said that when she needs help, the CNA has to try and find someone to help them. R #10 said they come in and turn off the light and tell her they need to find someone to help and then don't come back for 30 to 45 minutes.</p> <p>H. Record review of R #10's care plan dated 11/12/24, revealed R #10 requires assistance to meet basic ADL needs.</p> <p>I. Record review of R #10's Quarterly MDS dated [DATE], revealed R #10 is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>R #11</p> <p>J. On 02/19/25 at 10:55 AM, during an interview with CNA #11, she said there is not enough staff. CNA #10 said residents are having accidents and wetting themselves because they can't get to them in time. CNA #11 said R #11 needs assistance to get to the bathroom and he has had accidents because he can't wait.</p> <p>K. On 02/19/25 at 10:58 AM, during an interview, R #11 said has had to wait 30 minutes to an hour to get help because staff don't answer the call lights. R #11 said he has had quite a few accidents. R #11 said he needs help to go to the bathroom.</p> <p>L. Record review of R #11's care plan dated 11/19/24, revealed R #11 requires assistance to meet ADL needs.</p> <p>M. Record review of R #11's Quarterly MDS dated [DATE], revealed R #11 is partial/moderate assistance (helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Assistance with Oral Care</p> <p>N. Record review of R #24's Face Sheet revealed the following diagnosis of a Traumatic Brain Injury and was admitted to the facility in 2009.</p> <p>O. On 02/17/25 at 9:08 AM, during an interview, R #24's family member (FM) stated staff do not brush R #24's teeth daily after meals. R #24 is not interviewable.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>P. Record review of R #24's Quarterly MDS dated [DATE], revealed R #24 requires substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort).</p> <p>Q. Record review of R #24's care plan dated 12/03/24, revealed R #24 requires substantial/maximal assistance.</p> <p>R. Record review of R #24's ADL sheet, dated December 2024, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 12/11/24, staff did not document that R#24 received oral care after each meal.</li> <li>2. On 12/22/24, staff did not document that R#24 received oral care after each meal.</li> <li>3. On 12/29/24, staff did not document that R#24 received oral care after each meal.</li> </ol> <p>S. Record review of R #24's ADL sheet, dated January 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/01/25, staff did not document that R#24 received oral care after each meal.</li> <li>2. On 01/03/25, staff did not document that R#24 received oral care after each meal.</li> <li>3. On 01/05/25, staff did not document that R#24 received oral care after each meal.</li> <li>4. On 01/06/25, staff did not document that R#24 received oral care after each meal.</li> <li>5. On 01/07/25, staff did not document that R#24 received oral care after each meal.</li> <li>6. On 01/09/25, staff did not document that R#24 received oral care after each meal.</li> <li>7. On 01/12/25, staff did not document that R#24 received oral care after each meal.</li> <li>8. On 01/17/25, staff did not document that R#24 received oral care after each meal.</li> <li>9. On 01/19/25, staff did not document that R#24 received oral care after each meal.</li> <li>10. On 01/26/25, staff did not document that R#24 received oral care after each meal.</li> <li>11. On 01/28/25, staff did not document that R#24 received oral care after each meal.</li> <li>12. On 01/31/25, staff did not document that R#24 received oral care after each meal.</li> </ol> <p>T. Record review of R #24's ADL sheet, dated February 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 02/02/25, staff did not document that R#24 received oral care for all shifts.</li> <li>2. On 02/03/25, staff did not document that R#24 received oral care for all shifts.</li> <li>3. On 02/04/25, staff did not document that R#24 received oral care for all shifts.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 02/06/25, staff did not document that R#24 received oral care for all shifts.</p> <p>5. On 02/07/25, staff did not document that R#24 received oral care for all shifts.</p> <p>6. On 02/09/25, staff did not document that R#24 received oral care for all shifts.</p> <p>7. On 02/10/25, staff did not document that R#24 received oral care for all shifts.</p> <p>8. On 02/13/25, staff did not document that R#24 received oral care for all shifts.</p> <p>9. On 02/14/25, staff did not document that R#24 received oral care for all shifts.</p> <p>10. On 02/17/25, staff did not document that R#24 received oral care for all shifts.</p> <p>11. On 02/18/25, staff did not document that R#24 received oral care for all shifts.</p> <p>12. On 02/19/25, staff did not document that R#24 received oral care for all shifts.</p> <p>U. On 02/18/25 at 10:51 AM, during an interview with the CNA #9, he stated R #24 requires total assistance for oral hygiene. CNA #9 confirmed R #24 is scheduled for oral hygiene after meals. CNA #9 also stated R #24 can't do oral hygiene himself. CNA #9 confirmed he did not complete oral hygiene yet, as of the time of the interview.</p> <p>V. On 02/18/25 at 11:12 AM, during an interview with LPN #8, she confirmed R #24 receives oral hygiene daily, and R #24 can't complete oral hygiene alone. LPN #8 stated R #24's oral hygiene is done after every meal, and the CNAs are assigned to do it.</p> <p>R #24</p> <p>W. On 02/17/25 at 9:08 AM, during an interview with FM #24, she stated, R #24 is scheduled to get showered three times a week. FM #24 stated R #24 goes days without a shower, and R #24 had a noticeable smell. R #24 stated that she feels the R #24 is not getting showered due to the facility being short staffed. FM #24 confirmed she reported to the Administrator that the staff are not following the shower schedule because she felt they were short of staff.</p> <p>X. Record review of R #24's Quarterly MDS for ADL-bathing dated 01/23/25, revealed R #24 required substantial/maximal assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Y. Record review of R #24's care plan dated 12/03/24 for ADL-bathing revealed R #24 requires substantial/maximal assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Z. Record review of R #24's shower schedule no date revealed R #24 shower nights are Mondays, Wednesdays, and Fridays.</p> <p>AA. Record review of R #24's ADL documentation survey report for December 2024, revealed staff did not document showers were done for R #24 on the following dates:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. On 12/02/24, staff documented NA (not applicable) R #24 did not receive a shower day shift and no documentation for night shift.</li> <li>2. On 12/04/24, staff documented NA, R#24 did not receive a shower for all shifts.</li> <li>3. On 12/06/24, staff documented NA for night shift R #24 did not receive a shower.</li> <li>4. On 12/09/24, staff documented NA, R #24 did not receive a shower for all shifts.</li> <li>5. On 12/11/24, staff did not document R #24 did not receive a shower for all shifts.</li> <li>6. On 12/13/24, staff documented NA for night shift R #24 did not receive a shower.</li> <li>7. On 12/16/24, staff documented NA for day shift R #24 did not receive a shower and no documentation for night shift.</li> <li>8. On 12/18/24, staff documented NA staff documented NA (not applicable) R #24 did not receive a shower for all shifts.</li> <li>9. On 12/25/24, staff documented NA, R #24 did not receive a shower for all shifts.</li> <li>10. On 12/27/24, staff documented NA, R #24 did not receive a shower for night shift.</li> <li>11. On 12/30/24, staff documented NA, R #24 did not receive a shower for all shifts.</li> </ol> <p>BB. Record review of R #24's ADL documentation survey report dated January 2025 revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/08/25, staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</li> <li>2. On 01/20/25, staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</li> <li>3. On 01/24/25, staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</li> </ol> <p>CC. Record review of R #24's ADL, documentation survey report dated February 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 02/05/25, staff documented NA, R #24 did not receive a shower for night shift.</li> <li>2. On 02/12/25, staff documented NA, R #24 did not receive a shower for night shift.</li> <li>3. On 02/14/25, staff did not document that R #24 received a shower for all shifts.</li> <li>4. On 02/17/25, staff did not document that R #24 received a shower for all shifts.</li> </ol> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</b></p> <p>Based on record review and interviews, the facility failed to receive medication needed for treatment of an illness for 1 (R #4) of 4 (R #1, R #2, R #3, and R #4) residents reviewed for quality of care. Failure to follow physician orders could likely lead to facility staff and physician being unaware of changes in resident's condition and could likely lead to worsening of resident's condition. The findings are:</p> <p>A. Record review of R #4's admission record (no date) revealed R #4 was admitted to the facility on [DATE].</p> <p>B. Record review of R #4's change in condition evaluation dated 02/10/25 revealed R #4 presented with generalized weakness, altered mental status (change in awareness, movement and behaviors that stems from illnesses, disorders and injuries affecting your brain) and had an elevated temperature. She was tested for Covid-19 (coronavirus disease; acute disease in humans which is characterized mainly by fever and cough and can progress to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) and the results were positive.</p> <p>C. Record review of R #4's nursing progress note dated 02/10/25 at 5:04 PM revealed the following:</p> <ol style="list-style-type: none"> <li>1. Provider was notified of the positive Covid-19 results.</li> <li>2. Provider ordered antiviral medication (medication used to treat Covid -19) for R #4.</li> </ol> <p>D. Record review of R #4's physician's orders revealed an order dated 02/10/25, for Molnupiravir (antiviral medication for the treatment of mild-to-moderate COVID-19), give 800 mg by mouth two times a day for Covid for five days.</p> <p>E. Record review of R #4's Medication Administration Record (MAR) for February 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 02/10/25, for Molnupiravir bedtime dose staff documented medication was not given, see progress notes.</li> <li>2. On 02/11/25, for Molnupiravir bedtime dose staff documented medication was not given, see progress notes.</li> <li>3. On 02/12/25, for Molnupiravir bedtime dose staff documented medication was not given, see progress notes.</li> <li>4. On 02/13/25, for Molnupiravir bedtime dose staff documented medication was not given, see progress notes.</li> <li>5. On 02/11/25, for Molnupiravir morning dose staff documented medication not available.</li> <li>6. On 02/12/25, for Molnupiravir morning dose staff documented medication not available.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Calibre Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2029 Sagecrest Ave Las Cruces, NM 88011	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. On 02/13/25, for Molnupiravir morning dose staff documented medication not available.</p> <p>F. Record review of R #4's orders administration notes (staff notes regarding the administration of medication) for Molnupiravir revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 02/10/25 staff did not document why R #4 did not receive the medication.</li> <li>2. On 02/11/25 at 3:07 PM, staff documented that the pharmacy is waiting for approval from the DON to bill the facility for medication.</li> <li>3. On 02/12/25 at 3:49 AM, staff documented that the medication is pending delivery from the pharmacy.</li> <li>4. On 02/13/25 at 7:18 PM, staff documented that the medication is pending delivery from the pharmacy</li> </ol> <p>G. On 02/20/25 at 10:57 AM, during an interview, LPN #2, stated the following:</p> <ol style="list-style-type: none"> <li>1. On 02/11/25, she informed the ADON that she called the pharmacy and the pharmacy told her they required approval from the facility DON to bill the facility for R #4's Molnupiravir.</li> <li>2. LPN #2 did not contact the physician to advise her that R #4 had not received the Molnupiravir.</li> </ol> <p>H. On 02/20/25 at 11:39 AM, during an interview with physician #1, she stated that her expectation is for facility staff to contact her and inform her that R #4 had not received the Molnupiravir.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</b></p> <p>Based on record review and interview, the facility failed to ensure wound care orders were obtained and implemented for 1 (R #3) of 1 (R #3) residents reviewed for pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time). This deficient practice could likely result in the provider being unaware of the resident's current condition, leading to inconsistent interventions and worsening of pressure ulcers. The findings are:</p> <p>A. Record review of R #3's Admission Record (no date) revealed R #3 was admitted to the facility on [DATE].</p> <p>B. Record review R #3's admit data collection (assessment completed by nursing staff upon admission) dated 01/24/25 revealed the following:</p> <p>1. Stage II (shallow, open ulcer with a red-pink wound bed, without slough [non-viable tissue composed of dead cells accumulating on the wound surface. Can appear as a moist, yellow, tan, or white layer and is often fibrous or stringy in texture]) pressure injury to sacrum (area of spinal column just above the coccyx [tailbone, is a small triangle-shaped bone at the end of the spinal column]).</p> <p>C. Record review of R #3's provider progress note dated 01/27/25 revealed the following:</p> <p>1. Skin-pink warm and dry, patient with stage III (full thickness tissue loss, deep wounds that extend beyond the first two layers of the skin and may reveal subcutaneous (fatty) tissue, muscle, tendon, or even bone) pressure ulcer to coccyx.</p> <p>2. Wound care nurse evaluated today.</p> <p>D. Record review of R #3's physician's orders revealed an order date 01/27/25, wound care - cleanse site with normal saline (mixture of sodium chloride and water used to cleanse wounds), pat dry, apply calcium alginate (highly absorbent, biodegradable dressing made from seaweed that absorbs drainage and forms a gel), MediHoney (antibacterial wound gel made from honey) to wound bed cover with foam dressing (highly absorbent dressing that provides cushioning and protection). Change every other day and as needed.</p> <p>E. Record review of R #3's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed) for January 2025 revealed facility staff did not have orders in place for treatment of R #3's pressure ulcer for January 24 through January 26, 2025.</p> <p>F. Record review of R #3's TAR for January 2025 revealed facility staff did not have orders in place for treatment of R #3's pressure ulcer until 01/27/25.</p> <p>G. Record review of R #3's Nursing Progress Notes dated 01/24/25 through 01/26/25 revealed staff did not consult with the facility provider to obtain wound care orders until 01/27/25.</p> <p>H. On 02/19/25 at 4:37 PM, an interview with LPN #1, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Nursing staff that complete the admission and note that residents have a wound are responsible for obtaining orders if there are no current orders.</p> <p>2. Wound care was not started on R #3 until 01/27/25.</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47510</p> <p>Based on record reviews, observation, and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of 5 (R #8, R #10, R #11, R #25, and R #26) of 6 (R #8, R #10, R #11, R #24, R #25, and R #26) residents reviewed for staffing when staff failed to:</p> <ol style="list-style-type: none"> <li>1. To transfer R #8.</li> <li>2. Change R #10's brief.</li> <li>3. To assist R #11 to the toilet as needed.</li> <li>4. Assist R #24 with oral care and showers.</li> <li>5. Change R #25's brief after 30 minutes or longer.</li> </ol> <p>This deficient practice caused R #25 psychological distress, feeling embarrassed and crying when discussing how she was left soiled when she has to wait to be changed. The findings are:</p> <p>A. Record review of R #25's Admission Record, (Face Sheet) no date revealed the following:</p> <ol style="list-style-type: none"> <li>1. admitted [DATE].</li> <li>2. Diagnosis of Chronic Kidney Disease, Stage 4 (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood. Severe).</li> </ol> <p>B. Record review of R #25 physician orders revealed on 12/11/24, Torsemide Oral Tablet (Diuretic medicine that helps to remove excess water and sodium from the body through urine) 10 mg.</p> <p>C. Record review of R #25's MDS assessment dated [DATE], revealed R #25 is Dependent- (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.)</p> <p>D. On 02/18/25 at 9:33 AM, during an interview and observation with R #25, revealed R #25 was visibly in distress, head down with tears running down her face when discussing staffing. R #25 stated the facility is short staffed and she feels like they save her until they are done with all the other residents. R #25 stated staff take a long to answer the call lights. R #25 further stated when there is a storage of staff CNAs can take 30 minutes or longer to answer call lights. R #25 stated for the shift from 6:00 AM and 4:00 PM (day shift) is when there is staff shortage. R #25 stated the facility needs more help to answer the call lights faster. R #25 stated that when CNAs come they turn the call lights off and say they are short staffed, and she will need to wait. R #25 stated she feels embarrassed because she's left wet to wait for assistance for a long time.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 02/18/25 at 11:28 AM, during an observation by another resident's room, R #25 called out in hallway to surveyor, and R #25 stated I need help, I need to be changed. R #25 stated she had been waiting 25 minutes.</p> <p>F. On 02/19/25 at 1:52 PM, during an interview CNA #10 confirmed there is a lot of residents who use the Hoyer lift (a mechanical device that helps move people with limited mobility), and two people are always needed for safety. CNA #10 confirmed the residents complain that call lights are not being answered on time due to needing two staff to assist the residents with the hoier lift, leaving the unit without CNAs.</p> <p>G. On 02/18/25 at 10:12 am, during an interview with the ADON, she stated her expectation is that the call lights be answered within five minutes after the call light is activated. The ADON said if there is a resident that needs a two person assist that it will take a little longer to answer other call lights. The ADON said that she is not aware of any residents that have waited 15-30 minutes or longer for assistance.</p> <p>R #8</p> <p>H. On 02/18/25 at 8:41 AM, during an interview with CNA #8, he stated that on 02/16/25, in the morning, there were only two (2) CNA's working on the South Unit. CNA #8 said that there were 58 residents on the South Unit that day. CNA #8 said R #8 was assisted to the bathroom by the LPN #8 and Activity Director (AD) around 11:00 AM and was left on the toilet for approximately an hour. CNA #8 said he assisted another resident when he saw R #8 being assisted to the bathroom. CNA #8 said when he finished assisting another resident, he noticed R #8's call light was still on. CNA #8 said he went to R #8's room at 12:00 PM (02/16/25), R #8 was still on the toilet in her bathroom waiting for assistance.</p> <p>I. On 02/18/25 at 9:42 AM, during an interview, R #8 stated on 02/16/25, at 11:00 AM, she was assisted to the bathroom. R #8 said she was assisted with the Sara lift (a patient-assisting device that helps patients stand up and move around) and requires two people to help her. R #8 said when she finished in the bathroom, she turned on the call light. R #8 said it was a little before 12:00 PM, before CNA #8 was able to get her off the toilet. R #8 said she was upset and cried. R #8 further stated she felt like no one cared. R #8 said it takes 15 minutes to an hour for her call light to be answered. R #8 said that there is usually only one (1) CNA on her hall. R #8 said when she needs assistance getting out of bed or to the bathroom, she has to wait longer because the CNA assigned to her hall has to find someone to help.</p> <p>J. On 02/18/25 at 2:49 PM, during an interview, AD #8 stated on 02/16/25, she assisted LPN #8 transfer R #8 on the toilet. AD said she finished an activity with the residents and was asked to assist at approximately 11:00 AM. AD #8 stated there were only two CNA's on the South Unit and there were a lot of call lights on. AD #8 said she tried to help when she sees call lights, but she does not work the floor.</p> <p>K. On 02/19/25 at 10:50 AM, during an interview, CNA #10 said there are a lot of residents on the South Unit that are two people assist. CNA #10 said on 02/16/25 there was only two (2) CNA's and they were not able to complete showers, take vital signs, or complete any documentation. CNA #10 said the residents end up wetting themselves and have bowel movements because they can not get to them in time.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>L. On 02/18/25 at 10:12 am, during an interview ADON stated that it is not acceptable for a resident to be left on the toilet for an hour.</p> <p>R #10</p> <p>M. On 02/17/25 at 2:43 PM, during an interview, R #10 said she usually waits 45 minutes to get assistance. R #10 said she is a two person assist because she needs the hoyer lift. R #10 said there are a lot of residents on the South Unit that need the hoyer lift. R #10 said that there are only three (3) CNA's scheduled on the South Unit. R #10 said sometimes there are only two (2) CNA's for the entire unit. R #10 said when she needs help, the CNA has to try and find someone to help them. R #10 said they come in and turn off the light and tell her they need to find someone to help and then don't come back for 30 to 45 minutes.</p> <p>R #11</p> <p>N. On 02/19/25 at 10:55 AM, during an interview with CNA #11, she said there is not enough staff. CNA #10 said residents are having accidents and wetting themselves because they can't get to them in time. CNA #11 said R #11 needs assistance to get to the bathroom and he has had accidents because he can't wait.</p> <p>O. On 02/19/25 at 10:58 AM, during an interview, R #11 said he has had to wait 30 minutes to an hour to get help because staff don't answer the call lights. R #11 said he has had quite a few accidents. R #11 said he needs help to go to the bathroom.</p> <p>P. Record review of the transfer list dated 02/14/25 revealed the following:</p> <ol style="list-style-type: none"> <li>1. There are 17 residents on the South Unit that require the assistance of two staff members due to hoyer lift.</li> <li>2. There are seven residents on the South Unit that require the assistance of two staff members due to Sara lift.</li> <li>3. There are five residents on the North Unit that require the assistance of two staff members due to hoyer lift.</li> <li>4. There are two residents on the North Unit that require the assistance of two staff members due to Sara lift.</li> </ol> <p>R #24</p> <p>Q. On 02/17/25 at 9:08 AM, during an interview with R #24's sister stated staff do not brush R #24 teeth daily. R #24's sister stated that there is not enough staff. FM #24 she stated, R #24 is scheduled to get showered three times a week. FM #24 stated R #24 goes days without a shower, and R #24 had a noticeable smell. R #24 stated that she feels the R #24 is not getting showered due to the facility being short staffed. FM #24 confirmed she reported to the Administrator that the staff are not following the shower schedule because she felt they were short of staff.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R. Record review of R #24's Quarterly Minimum Data Set (MDS) dated [DATE], revealed R #24 requires substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). For ADL-bathing, R #24 requires substantial/maximal assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>S. Record review of R #24's care plan dated 12/03/24, revealed R #24 requires substantial/maximal assistance. ADL-bathing revealed R #24 requires substantial/maximal assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>T. Record review of R #24's ADL sheet for December 2024, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 12/11/24, R #24 did not receive any oral care.</li> <li>2. On 12/22/24, R #24 did not receive any oral care.</li> <li>3. On 12/29/24, R #24 did not receive any oral care.</li> </ol> <p>U. Record review of R #24's ADL sheet for January 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/01/25, R #24 did not receive any oral care.</li> <li>2. On On 01/03/25, R #24 did not receive any oral care.</li> <li>3. On 01/05/25, R #24 did not receive any oral care.</li> <li>4. On 01/06/25, R #24 did not receive any oral care.</li> <li>5. On 01/07/25, R #24 did not receive any oral care.</li> <li>6. On 01/09/25, R #24 did not receive any oral care.</li> <li>7. On 01/12/25, R #24 did not receive any oral care.</li> <li>8. On 01/17/25, R #24 did not receive any oral care.</li> <li>9. On 01/19/25, R #24 did not receive any oral care.</li> <li>10. On 01/26/25, R #24 did not receive any oral care.</li> <li>11. On 01/28/25, R #24 did not receive any oral care.</li> <li>12. On 01/31/25,R #24 did not receive any oral care.</li> </ol> <p>V. Record review of R #24's ADL sheet for February 2025, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 02/02/25, R #24 did not receive any oral care.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>2. On 02/03/25, R #24 did not receive any oral care.</li> <li>3. On 02/04/25, R #24 did not receive any oral care.</li> <li>4. On 02/06/25, R #24 did not receive any oral care.</li> <li>5. On 02/07/25, R #24 did not receive any oral care.</li> <li>6. On 02/09/25, R #24 did not receive any oral care.</li> <li>7. On 02/10/25, R #24 did not receive any oral care.</li> <li>8. On 02/13/25, R #24 did not receive any oral care.</li> <li>9. On 02/14/25, R #24 did not receive any oral care.</li> <li>10. On 02/17/25, R #24 did not receive any oral care.</li> <li>11. On 02/18/25, R #24 did not receive any oral care.</li> <li>12. On 02/19/25, R #24 did not receive any oral care.</li> </ol> <p>W. On 02/18/25 at 10:51 AM, during an interview, CNA #9 stated R #24 requires total assistance for oral hygiene. CNA #9 confirmed R #24 is scheduled for oral hygiene after meals. CNA #9 confirmed R #24 need assistance because R #24 is unable do oral hygiene himself. CNA #9 confirmed he did not complete oral hygiene for R #24 on 02/18/25.</p> <p>X. Record review of R #24's shower schedule revealed R #24 shower days are Mondays, Wednesdays, and Fridays.</p> <p>Y. Record review of R #24's ADL documentation survey report for December 2024, revealed staff did not document showers were done for R #24 on the following dates:</p> <ol style="list-style-type: none"> <li>1. On 12/02/24, Staff documented NA (not applicable) R #24 did not receive a shower day shift and no documentation for night shift.</li> <li>2. On 12/04/24, Staff documented NA, R#24 did not receive a shower for all shifts.</li> <li>3. On 12/06/24, Staff documented NA for night shift R #24 did not receive a shower.</li> <li>4. On 12/09/24, Staff documented NA, R #24 did not receive a shower for all shifts.</li> <li>5. On 12/11/24, Staff did not document R #24 did not receive a shower for all shifts.</li> <li>6. On 12/13/24, Staff documented NA for night shift R #24 did not receive a shower.</li> <li>7. On 12/16/24, Staff documented NA for day shift R #24 did not receive a shower and no documentation for night shift.</li> </ol> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>8. On 12/18/24, Staff documented NA, staff documented NA (not applicable) R #24 did not receive a shower for all shifts.</p> <p>9. On 12/25/24, Staff documented NA, R #24 did not receive a shower for all shifts.</p> <p>10. On 12/27/24, Staff documented NA, R #24 did not receive a shower for night shift.</p> <p>11. On 12/30/24, Staff documented NA, R #24 did not receive a shower for all shifts.</p> <p>Z. Record review of R #24's ADL documentation survey report dated January 2025 revealed the following:</p> <p>1. On 01/08/25, Staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</p> <p>2. On 01/20/25, Staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</p> <p>3. On 01/24/25, Staff documented NA that R #24 did not receive a shower day shift and no documentation for night shift.</p> <p>AA. Record review of R #24's ADL, documentation survey report dated February 2025, revealed the following:</p> <p>1. On 02/05/25, Staff documented NA, R #24 did not receive a shower for night shift.</p> <p>2. On 02/12/25, Staff documented NA, R #24 did not receive a shower for night shift.</p> <p>3. On 02/14/25, Staff did not document that R #24 received a shower for all shifts.</p> <p>4. On 02/17/25, Staff did not document that R #24 received a shower for all shifts.</p> <p>5. On 02/19/25, Staff did not document that R #24 received a shower for all shifts.</p> <p>BB. On 02/20/25 at 12:26 PM, during an interview, CNA #28 stated she follows the shower schedule but when the facility is short staffed, sometimes shower don't happen. CNA #28 further stated that if there is enough staff the resident who missed a shower will get a shower on next day if possible.</p> <p>CC. On 02/20/25 at 12:36 PM, during an interview, CNA #8 stated showers happen as scheduled for the most part but, when the facility is short staffed, the CNAs don't do showers. Sometimes the next day it's already too busy and CNAs don't have time to make up showers.</p> <p>DD. On 02/14/25 at 3:01 PM, during an observation of the North Unit, there were 46 residents and two CNA's working the unit.</p> <p>EE. On 02/14/25 at 3:10 PM, during an observation of the South Unit, there were 56 residents and two CNA's working the unit.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Calibre Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2029 Sagecrest Ave Las Cruces, NM 88011	

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F 0725  Level of Harm - Actual harm  Residents Affected - Few	52223

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on record review and interview, the facility failed to ensure nursing staff demonstrated competency in the skills and techniques necessary to safely change a suprapubic catheter (a thin flexible tube inserted directly into the bladder through a small incision in the lower abdomen, just above the pubic bone. It is used to drain urine from the bladder when a person is unable to urinate normally) for residents for 1 (ADON) of 1 (ADON) employees sampled for training and competency. This deficient practice could likely result in nurses working with residents without adequate knowledge and skills to do so; likely resulting in injury or inappropriate care being provided to the residents. The findings are:</p> <p>A. Record review of R #17's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17 was admitted to the facility on [DATE].</li> <li>2. R #17 had the following diagnoses:             <ol style="list-style-type: none"> <li>a. Acute Cystitis with Hematuria [a condition where someone experiences an inflammation of the bladder (acute cystitis) accompanied by blood in the urine (hematuria)].</li> <li>b. Need for assistance with personal care.</li> <li>c. Obstructive and Reflux Uropathy (obstructive uropathy occurs when the urine can't drain normally, reflux occurs when urine flows backward into the upper urinary tract).</li> </ol> </li> </ol> <p>B. Record review of R #17's nursing progress note, dated 01/12/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17 had bright red blood in his brief (disposable diapers designed for adults who have incontinence or limited mobility).</li> <li>2. The doctor was in the facility and gave orders to send R #17 to the emergency room .</li> </ol> <p>C. Record review of R #17's provider progress note, dated 01/12/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17's suprapubic catheter was changed by the nurse.</li> <li>2. The nurse reported to the provider that there was no drainage from R #17's catheter after she changed it.</li> <li>3. The nurse reported that there was blood and no urine drainage when she flushed the catheter.</li> <li>4. R #17 had blood coming out of his urethra (the hollow tube that lets urine, a waste product, leave the body).</li> <li>5. R #17 had decreased urine output.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. R #17 reported bladder pain.</p> <p>7. The provider gave orders to send R #17 to the emergency room .</p> <p>D. Record review of R #17's hospital records, dated 01/12/25 through 01/13/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17's suprapubic catheter had been replaced by the staff at the skilled nursing facility and R #17 began to experience suprapubic (area above the pubis, which is the bony structure at the front of the pelvis) pain and blood from his urethra.</li> <li>2. R #17's computed tomography (CT) scan revealed that the suprapubic catheter balloon was inflated in R #17's prostate.</li> <li>3. The urologist (a surgeon who specializes in the urinary tract, reproductive system, and adrenal glands) recommended replacement of the suprapubic catheter.</li> <li>4. R #17 was admitted to the hospital for observation.</li> <li>5. R #17 was discharged from the hospital on 01/13/25.</li> </ol> <p>E. Record review of R #17's progress note, dated 01/13/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17 returned to the facility.</li> <li>2. R #17 had a diagnosis of a displaced supra pubic catheter.</li> <li>3. R #17 denied pain or discomfort.</li> </ol> <p>F. On 02/18/25 at 3:25 PM, during an interview, the ADON stated the following:</p> <ol style="list-style-type: none"> <li>1. On 01/12/25, R #17's family member requested for her to flush (pushing saline (salty water) through a catheter inserted in the bladder to prevent a build-up of mucus within the bladder) R #17's supra pubic catheter.</li> <li>2. R #17's catheter was dirty so she decided it needed to be replaced.</li> <li>3. R #17 had blood in his brief approximately three to four hours after the catheter was changed.</li> <li>4. She notified the provider after she noticed blood in R #17's brief.</li> <li>5. The provider assessed R #17 and ordered for him to be sent to the hospital.</li> <li>6. R #17 returned to the facility the next day.</li> <li>7. R #17 did not have any complications after returning from the hospital.</li> </ol> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. She stated that she completed several competencies with the previous ADON when she started in December 2024 (she was unable to state which competencies she completed).</p> <p>9. She could not remember if she completed a competency regarding suprapubic catheter changes.</p> <p>G. Record review of the ADON's Licensed Nurse Competency forms, dated 12/24/24, revealed the following:</p> <ol style="list-style-type: none"> <li>1. The ADON's hire date was 12/19/24.</li> <li>2. The assessment method for the competency of Urinary catheterization was documented as oral (a type of examination where a person is questioned verbally).</li> <li>3. There was no documentation that the competency included a skills check off (a supervised assessment of a person's ability to perform a skill or procedure).</li> <li>4. There was no date for the completion of the basic nursing skills competencies.</li> <li>5. There were no initials from the educator indicating that the competencies were completed.</li> </ol> <p>H. On 02/19/25 at 9:19 AM, during an interview with the Nurse Educator (NE), the following was confirmed:</p> <ol style="list-style-type: none"> <li>1. The basic nursing skills competencies that are completed by nursing staff are verbal competencies and the nurses tell her what they would do for each skill.</li> <li>2. She does not complete a step-by-step check-off for each of the competencies.</li> <li>3. She does not observe a return demonstration for the staff to demonstrate competency for each basic nursing skill.</li> <li>4. She stated that she completed an in-service regarding catheter changes and suprapubic catheter changes after R #17 returned from the hospital on 01/13/25 (she did not remember the date).</li> <li>5. She did not observe the ADON perform a return demonstration of replacing a urinary catheter or a suprapubic catheter.</li> </ol>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47510</p> <p>Based on observation and interview, the facility failed to store and serve food under sanitary conditions in accordance with professional standards of food service safety for all 98 residents in the facility (residents were identified on the resident matrix provided by the DON on 02/13/25) who eat food prepared in the kitchen when staff failed to:</p> <ol style="list-style-type: none"> <li>1. Keep the deep freezer and kitchen floors clean.</li> <li>2. Keep the stoves and surrounding areas clean from oil.</li> <li>3. Maintain the quality of the oil (fresh) in the deep fryer.</li> <li>4. Perform hand hygiene prior to assisting R #24 with meal.</li> </ol> <p>These deficient practices could likely lead to foodborne illnesses. The findings are:</p> <p>A. On 02/14/25 at 11:16 AM, during an observation of the kitchen revealed the following:</p> <ol style="list-style-type: none"> <li>1. The floors in the deep freezer and kitchen had food particles/paper, spilled liquid, and were sticky.</li> <li>2. The oil in the deep fryer was dark and smokey and had food particles floating on top of the oil.</li> <li>3. The floor under and the appliances next to the deep fryer were covered in oil.</li> <li>4. Coffee spilled on the floor.</li> <li>5. Jelly in the refrigerator was not covered.</li> <li>6. A straw, and cup lids on the floor around the trash cans by the dishwasher.</li> <li>7. A blanket on the floor under a sink that appeared wet and dirty.</li> <li>8. The drain on the floor was backed up with food particles and paper trash.</li> </ol> <p>B. On 02/14/25 at 11:24, during an interview, the Kitchen Manager (KM) confirmed that there were crumbs in the deep fryer, and the deep fryer, appliances and floor had a build up of oil and crumbs. The KM confirmed the jelly was not covered and the walk in floor was not clean. The KM also confirmed a blanket was on the floor under the sink and said the blanket was to clean up a leak. The KM confirmed straws and lids on the floor in the dishwasher area.</p> <p>C. On 02/14/25 at 12:10 PM, during an observation of the Assisted Dining Room revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. R #24 was sitting at a table in the dining room with his meal in front of him, CNA #29 assisted R #24.</p> <p>2. CNA #29 adjusted R #24's feet on the footrest and the brake on the wheelchair.</p> <p>3. CNA #29 did not perform hand hygiene before she resumed assisting R #24.</p> <p>D. On 02/14/25 at 12:10 PM, during an interview CNA #29 she confirmed she did perform hand hygiene prior to resuming assistance to R #24 after adjusting R #24's feet on the footrests and brake on wheelchair. CNA #29 confirmed that she should have.</p> <p>52223</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #17 and R #18) of 2 (R #17 and R #18) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are:</p> <p>R #17</p> <p>A. Record review of R #17's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17 was admitted to the facility on [DATE].</li> <li>2. R #17 had the following diagnoses:             <ol style="list-style-type: none"> <li>a. Acute Cystitis with Hematuria [a condition where someone experiences an inflammation of the bladder (acute cystitis) accompanied by blood in the urine (hematuria)].</li> <li>b. Need for assistance with personal care.</li> <li>c. Obstructive and Reflux Uropathy (obstructive uropathy occurs when the urine can't drain normally, reflux occurs when urine flows backward into the upper urinary tract).</li> </ol> </li> </ol> <p>B. Record review of R #17's progress note, dated 01/12/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17 had bright red blood in his brief (disposable diapers designed for adults who have incontinence or limited mobility).</li> <li>2. The doctor was in the facility and gave orders to send R #17 to the emergency room .</li> </ol> <p>C. Record review of R #17's provider progress note, dated 01/12/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #17's suprapubic catheter lower abdomen, just above the pubic bone. (It is used to drain urine from the bladder when a person is unable to urinate normally) was changed by the nurse.</li> <li>2. The nurse reported to the provider that there was no drainage from R #17's catheter after she changed it.</li> <li>3. The nurse reported that there was blood and no urine drainage when she flushed the catheter.</li> <li>4. R #17 had blood coming out of his urethra (the hollow tube that lets urine, a waste product, leave the body).</li> <li>5. R #17 had decreased urine output.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. R #17 was reporting bladder pain.</p> <p>7. The provider gave orders to send R #17 to the emergency room .</p> <p>D. Record review of R #17's entire medical record, no date, revealed the record did not contain any documentation of the following:</p> <ol style="list-style-type: none"> <li>1. R #17's suprapubic catheter was changed on 01/12/25.</li> <li>2. Urine output at the time of the suprapubic catheter change.</li> <li>3. An assessment of how R #17 tolerated the suprapubic catheter change.</li> </ol> <p>E. On 02/18/25 at 3:25 PM, during an interview with the ADON, stated the following:</p> <ol style="list-style-type: none"> <li>1. On 01/12/25, R #17's family member requested for her to flush (pushing saline (salty water) through a catheter inserted in the bladder to prevent a build-up of mucus within the bladder) R #17's supra pubic catheter.</li> <li>2. R #17's catheter was dirty so she decided it needed to be replaced.</li> <li>3. R #17 had blood in his brief approximately three to four hours after the catheter was changed.</li> <li>4. She notified the provider after she noticed blood in R #17's brief.</li> <li>5. The provider assessed R #17 and ordered for him to be sent to the hospital.</li> <li>6. R #17 returned to the facility the next day.</li> <li>7. She confirmed there was no documentation in the medical record of R #17's suprapubic catheter was changed on 01/12/25.</li> <li>8. She confirmed the medical record did not contain documentation regarding R #17's urine output at the time of the suprapubic catheter change or how R #17 tolerated the suprapubic catheter change.</li> <li>9. She confirmed staff are expected to document any procedure that is performed.</li> <li>10. She confirmed staff are expected to document any concerns that are identified and when they notified the provider and any orders from the provider.</li> </ol> <p>F. Record review of the facility's Indwelling (foley) Catheter Removal policy, revised August 2022, revealed the following:</p> <ol style="list-style-type: none"> <li>1. Document the following in the resident's medical record: <ol style="list-style-type: none"> <li>a. The date and time the procedure was performed.</li> <li>b. The name and title of the individual(s) who performed the procedure.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. All assessment data (e.g., urine amount, color, clarity, etc.) obtained during the procedure.</p> <p>d. The time and amount of first void after catheter removal.</p> <p>e. How the resident tolerated the procedure .</p> <p>R #18</p> <p>G. Record review of R #18's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #18 was admitted to the facility on [DATE].</li> <li>2. R #18 had the following diagnoses: <ul style="list-style-type: none"> <li>a. Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that cause airflow obstruction and breathing problems).</li> <li>b. Type 2 Diabetes Mellitus with Hyperglycemia (a chronic condition where the body does not use insulin properly or does not produce enough insulin, leading to high blood sugar levels (hyperglycemia).</li> <li>c. Cirrhosis of Liver (a chronic liver disease characterized by the permanent scarring of the liver tissue).</li> <li>d. Peripheral Vascular Disease (a condition that affects the blood vessels outside of the heart and brain).</li> <li>e. Diastolic (Congestive) Heart Failure (occurs when the left ventricle of the heart stiffens and can't relax normally).</li> <li>f. Hypertensive Heart Disease with Heart Failure (condition that occurs when chronic high blood pressure leads to heart damage and heart failure).</li> <li>g. Personal History of Other Venous Thrombosis and Embolism (refers to a previous occurrence of blood clots in the veins, other than deep vein thrombosis (DVT) and pulmonary embolism (PE)).</li> <li>h. Personal History of Nicotine Dependence (current pattern of using nicotine-containing products).</li> <li>i. Reduced Mobility (the inability to move around freely and without pain).</li> </ul> </li> </ol> <p>H. Record review of R #18's nursing progress note, dated 02/14/25 at 6:32 AM, revealed the following:</p> <ol style="list-style-type: none"> <li>1. The night nurse notified the day shift nurse R #18 was having trouble breathing.</li> <li>2. R #18 was assessed by the day shift nurse and the following was identified:</li> </ol> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. R #18 used a non-rebreather (an oxygen mask that delivers high concentrations of oxygen. It's for emergency situations when a person needs oxygen quickly) at 15 Liters of oxygen per minute (LPM).</p> <p>b. R #18 had difficulty breathing.</p> <p>c. R #18 refused to be transferred to the hospital.</p> <p>d. R #18 was educated about his status and continued to refuse to be transferred to the hospital.</p> <p>e. The provider was aware of the situation.</p> <p>f. The day shift nurse notified the DON and ADON about R #18's difficulty breathing and refusal to go to the hospital.</p> <p>l. On 02/20/25 at 10:18 AM, during an interview, LPN #16 stated the following:</p> <ol style="list-style-type: none"> <li>1. He was the day shift nurse that worked with R #18 on 02/14/25.</li> <li>2. LPN #17 was the night shift nurse that worked with R #18 on the evening of 02/13/25 to the morning of 02/14/25.</li> <li>3. LPN #17 gave him the following report regarding R #18:           <ol style="list-style-type: none"> <li>a. R #18 had difficulty breathing.</li> <li>b. She had received orders for a chest X-ray (CXR, an imaging test that uses electromagnetic radiation to create detailed images of the internal structures of the chest, including the lungs, heart, and ribs) for R #18.</li> <li>4. He was unsure how long R #18 had been having trouble breathing prior to his arrival.</li> <li>5. He gave R #18 a breathing treatment and R #18's breathing started to improve.</li> <li>6. He was able to get R #18 off the non-rebreather and on a nasal cannula (a device that gives additional oxygen through the nose) at 4 LPM of oxygen.</li> <li>7. The results of R #18's CXR showed that he had left lower lobe atelectasis (a condition where part or all of a lung collapses, leading to a decrease in gas exchange).</li> <li>8. He contacted the provider with the results of the CXR and received orders for scheduled nebulizer treatments and Levoquin (an antibiotic medication that treats bacterial infections).</li> <li>9. He reassessed R #18 oxygen saturation and effort of breathing approximately every 2 hours after he started his shift.</li> <li>10. R #18 started yelling that he was having trouble breathing and he notified the DON and ADON that he was sending him to the hospital.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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  02/20/2025
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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11. R #18 continued to refuse to go to the hospital, but he called 911 anyway because R #18's breathing status was so bad.</p> <p>J. On 02/20/24 at 11:58, during an interview, Advanced Practice Nurse (APN) #16 stated the following:</p> <ol style="list-style-type: none"> <li>1. Between the hours of 7 PM and 7 AM, staff contact the on-call service for any concerns regarding residents.</li> <li>2. On 02//14/25 at 5:50 AM, staff messaged on-call with the following information regarding R #18 <ol style="list-style-type: none"> <li>a. Staff had given R #18 a duo-nebulizer treatment 20 minutes prior to contacting on-call.</li> <li>b. R #18 was on a non-rebreather mask at 15 LPM of oxygen and had an oxygen saturation in the high 70's (normal is 95% to 100%).</li> <li>c. R #18 refused to go to the hospital.</li> </ol> </li> <li>3. On-call gave the following orders: <ol style="list-style-type: none"> <li>a. Give another DuoNeb to be given right away.</li> <li>b. Serial (scheduled) DuoNeb (did not state the frequency).</li> <li>c. Stat (latin word meaning immediately) CXR.</li> </ol> </li> </ol> <p>K. Record review of R #18's entire medical record, no date, revealed staff did not document the following:</p> <ol style="list-style-type: none"> <li>1. When R #18 started having trouble breathing.</li> <li>2. Assessment of R #18 breathing status prior to 6:32 AM on 02/14/25.</li> <li>3. Oxygen saturations and lung sounds of R #18 throughout the day on 02/14/25.</li> <li>4. When the on-call provider was contacted and any orders that were received for R #18 prior to 06:32 AM.</li> <li>5. Administration of DuoNeb treatments.</li> </ol> <p>L. On 02/20/25 at 10:07 AM, during an interview with the ADON, the following was confirmed:</p> <ol style="list-style-type: none"> <li>1. Staff were expected to document all resident assessments.</li> <li>2. Staff were expected to document all contact with providers.</li> <li>3. Staff were expected to document any orders received from providers.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Staff were expected to document all treatments that were given to residents.</p>