STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to notify the provider of missed medication doses for 1 (R #25) of 3 (R #18, R #25 and R #26) residents reviewed for medications not available when staff failed to: 1. Notify the provider of the missed dose of Amiodarone (medication used to treat affects the rhythm of your heartbeats. It is used to help keep the heart beating normally in people with life-threatening heart rhythm disorders of the ventricles) on 06/14/25 and 06/15/25. 2. Notify the provider of the missed dose of Levothyroxine (medication used to treat hypothyroidism underactive thyroid; a condition where the thyroid gland does not produce enough thyroid hormone) on 6/14/25 and 6/15/25. These deficient practices could likely result in residents not receiving the necessary care or worsening medical conditions due to lack of treatment. The findings are: A. Record review of R #25's face sheet, no date, revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 diagnoses include the following: a. Hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure). b. Paroxysmal arterial fibrillation (a type of irregular heartbeat). c. Atherosclerotic heart disease of native coronary artery without angina pectoris (is caused by the buildup of plaque (fats, cholesterol, and other substances) in the arteries, leading to narrowed arteries and reduced blood flow). d. Chronic systolic (congestive) heart failure (systolic heart failure, the left ventricle of your heart, which pumps most of the blood, has become weak). e. Cardiomegaly (an enlarged heart, is an indicator of a condition that puts a strain on your heart). (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
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Hypothyroidism, unspecified (thyroid gland doesn't make and release enough hormone into your bloodstream). B. Record review of R #25's physician orders, dated 06/11/24, revealed the following: 1. An order for amiodarone HCl oral tablet 200 mg give 200 mg via G-tube at bedtime for arrythmia. 2. An order for Levothyroxine sodium oral tablet 112 mcg give 1 tablet via G-tube one time a day for hypothyroidism. C. Record review of R #25's MAR, dated June 2025, revealed the following: 1. Staff documented R #25's amiodarone code 9; (other see progress note effective) medication not available on the following dates: a. 06/14/25, b. 06/15/25. 2. Staff documented R #25's levothyroxine medication code 13; (medication not available effective) on the following dates: a. 06/14/25, b. 06/15/25. D. Record review of R #25's progress notes for 06/14/25 and 06/15/25, revealed staff did not notify the physician of the following: 1. R #25's amiodarone medication not available on 06/14/25 and 06/15/25. 2. R #25's levothyroxine medication not available on 06/14/25 and 06/15/25. E. On 06/17/25 at 9:13 am, during an interview, Licensed Vocational Nurse (LVN) #26, stated the following: 1. Confirmed R #25's order for amiodarone HCl oral tablet 200 mg give 200 mg via G-tube at bedtime for arrythmia. 2. Confirmed R #25's order for Levothyroxine sodium oral tablet 112 mcg give 1 tablet via G-tube one time a day for hypothyroidism. F. On 06/18/25 at 9:55 am, during an interview, the DON confirm the following: 1. Staff are expected to notify the provider if a resident refuses medication or if medication is not available. 2. Staff are expected to document all contact with the provider in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; federally mandated assessment instrument completed by facility staff) was accurate for 1 (R #16) of 3 (R #16, R #17, and R #18) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: A. Record review of R #16's admission documents, no date, revealed R #16 was admitted to the facility on [DATE]. B. Record review of R #16's progress note, dated 05/07/25, revealed the following: 1. R #16 fell. 2. R #16 had a bruise noted to the side of her left eye. 3. R #16 had redness to her forehead, left shoulder, left hip, and both knees. C. Record review of R #16's quarterly MDS, dated [DATE], revealed staff documented the following: 1. R #16 had one fall with no injury. 2. R #16 had zero falls with injury (except major; skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain). 3. R #16 had zero falls with major injury. D. On 06/16/25 at 3:47 PM, during an interview, the MDS coordinator confirmed the following: 1. R #16 fell on [DATE]. 2. R #16 had bruising to her left eye and redness to her forehead, left shoulder, left hip, and both knees. 3. On R #16's quarterly MDS assessment, staff documented that R #16 had one fall without injury. 4. R #16's quarterly MDS assessment was inaccurate, and staff should have documented that R #16 had one fall with injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, record review and interview, the facility failed to ensure care plan revisions occurred for 3 (R #8, R #17, and R #25) of 3 (R #8, R #17, and R #25) residents when the staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #8 A. On 06/16/25 at 10:03 AM, during an observation of R #8's room the smell of urine became extremely strong. R #8 sat on his bed with nothing on only a brief. The brief appeared to be extremely soiled and was dark in color. The mattress did not have any sheets. B. On 06/17/25 at 8:50 AM, during an interview, the ADON said that R #8 will go days without letting anyone change his brief. The ADON said that R #8 will kick, throw things, and cuss at staff if he doesn't want to be changed. The ADON said that R #8 does not like sheets on his bed. The ADON further stated R #8 will take the sheets off his bed if they put them on. The ADON said that they are not able to shower R #8. The ADON said that when the resident is compliant with care, staff will do as much as they can for him. The DON said staff will reproach R #8 several times throughout the day to see if R #8 will allow them to change him, shower him, and put sheets on the resident's bed. The ADON said that they have changed R #8's mattress several times due to the smell. The ADON said that staff have to continue to ask the resident throughout the day if he will let them provide any care for him. The ADON said that R #8 will sometime let staff provide care if you offer him a Diet Dr. Pepper and chips. C. Record review of R #8's care plan, dated 04/10/25, did not contain the following documentation: 1. R #8's occasional compliance with care when Diet Dr. Pepper or chips are offered. 2. Interventions for care and refusals. 3. Interventions for changing R #8's sheets and refusals of allowing sheets on his bed. 4. Interventions for refusals of showering/bathing for R #8. 5. When and how often R #8's mattress should be changed. D. On 06/17/25 at 2:24 PM, during an interview, the DON said that she would expect staff to document when R #8 refuses to have sheets on his bed. The DON said Dr. Pepper and chips don't always work with the resident, but that it is used as an intervention. The DON confirmed the drink and chips intervention was not documented. The DON confirmed the interventions for R #8 were documented by the previous staff and have not been updated since 11/15/24. The DON said her expectation was that the care plan be updated and that interventions for refusal of care should be documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #17 E. Record review of R #17's admission documents, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 had the following diagnoses: a. Muscle weakness. b. Lack of coordination. c. Abnormalities of gait and mobility. d. Difficulty in walking. F. Record review of R #18's progress note, dated 04/07/25, revealed the following: 1. R #17 had a fall on 04/05/25. 2. R #17 fell due to weakness and imbalance. 3. The intervention put in place due to R #17's fall was for R #17 to participate in the restorative program (nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible). G. Record review of R #17's care plan, revised 12/30/24, revealed staff did not revise R #17's care plan to include that she was participating in the restorative program. H. On 06/17/25 at 1:39 PM, during a joint interview, the DON and MDS Director confirmed the following: 1. R #17 fell on [DATE]. 2. R #17 was participating in the restorative program to improve her weakness and balance. 3. Staff did not revise R #17's care plan to include that she was participating in the restorative program. 4. Staff should have revised R #17's care plan to include the restorative program as an intervention to prevent falls. R #25 I. Record review of R #25's admission documents, no date, revealed she was admitted to the facility on [DATE]. J. Record review of R #25's physician orders, multiple dates revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. An order dated 07/19/24 regular diet, regular texture, regular/thin consistency 2. An order dated 06/17/25 enteral feed five times a day isosource 1.5 250ml of formula (a specialized liquid nutritional supplement designed to provide essential nutrients to individuals who may have difficulty meeting their nutritional needs through regular food intake) at each feeding as tolerated. 3. An order dated 06/11/24 Amiodarone HCl oral tablet 200 mg give 200 mg via gastrostomy tube (G-tube a tube inserted through the belly that brings nutrition directly to the stomach) at bedtime for arrythmia (irregular heart beat). 4. An order dated 06/11/24 Levothyroxine sodium oral tablet 112 mcg give 1 tablet via G-tube one time a day for hypothyroidism (thyroid gland doesn't make and release enough hormone into your bloodstream). K. Record review of R #25's care plan, dated 04/17/25, revealed R #25 is to only have female staff for direct care on resident. No specific details in care plan interventions. L. On 06/18/25 at 9:55 AM, during an interview, the DON confirmed R #25's care plan does not justify if a male staff member is to feed and administer medication to R #25, and what plan to follow to ensure resident is fed and medications are given per physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #25) of 3 (R #18, R #25, and R #26) residents reviewed for neglect, when staff failed to administer R #25's heart rhythm and thyroid medication as ordered by the physician. This deficient practice could likely lead to the residents medical conditions worsening and 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: A. Record review of R #25's face sheet, no date, revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 diagnoses include the following: a. Gastrostomy status (is a surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage). b. Epilepsy, unspecified, intractable, with status epilepticus (a potentially life-threatening state in which a person experiences an abnormally prolonged seizure (any seizure lasting longer than five minutes) or does not fully regain consciousness between seizures). c. Hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure). d. Paroxysmal arterial fibrillation (a type of irregular heartbeat). e. Atherosclerotic heart disease of native coronary artery without angina pectoris (is caused by the buildup of plaque fats, cholesterol, and other substances in the arteries, leading to narrowed arteries and reduced blood flow). f. Chronic systolic (congestive) heart failure (systolic heart failure, the left ventricle of your heart, which pumps most of the blood, has become weak). g. Cardiomegaly (an enlarged heart is an indicator of a condition that puts a strain on your heart). h. Hypothyroidism, unspecified (thyroid gland doesn't make and release enough hormone into your bloodstream). B. Record review of R #25's physician orders, multiple dates revealed the following: 1. An order dated 07/19/24 regular diet, regular texture, regular/thin consistency (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An order dated 06/17/25 enteral feed five times a day isosource 1.5 250 ml of formula (a specialized liquid nutritional supplement designed to provide essential nutrients to individuals who may have difficulty meeting their nutritional needs through regular food intake) at each feeding as tolerated at each feeding as tolerated. 3. An order dated 06/11/24 Amiodarone HCl oral tablet 200 mg give 200 mg via gastrostomy tube (G-tube a tube inserted through the belly that brings nutrition directly to the stomach) at bedtime for arrythmia (irregular heart beat). 4. An order dated 06/11/24 Levothyroxine sodium oral tablet 112 mcg give 1 tablet via G-tube one time a day for hypothyroidism. C. Record review of R #25's MAR dated May 2025, revealed staff documented the following: 1. On 06/14/25 for amiodarone dose scheduled for Hour of Sleep (HS) administration, staff documented code 9; (other/see progress note effective) on order. 2. On 06/14/25 for levothyroxine dose scheduled for 0500 administration, staff documented code 13; (medication not available effective) none in med dispenser. 3. On 06/15/25 for levothyroxine dose scheduled for 0500 administration, staff documented code 13; (medication not available effective) medication on order. D. Record review of R #25's progress notes for 06/14/25 and 06/15/25, revealed staff did not notify the physician of the following: 1. R #25's amiodarone medication not available on 06/14/25 and 06/15/25. 2. R #25's levothyroxine medication not available on 06/14/25 and 06/15/25. E. Record review of R #25's progress notes on 06/14/25 and 06/15/25 dates revealed the provider was not notified of medication not given to R #25. F. On 06/18/25 at 8:35 AM, during an interview with Licensed Vocational Nurse (LVN) #26, stated he was the nurse assigned to R #25. LVN #26 stated he doesn't give R #25 her medications or G-tube feedings due to R #25 not wanting males to work with her. LVN #26 stated he didn't know if R #25 received her meds or G-tube feeding on 06/18/25. LVN #26 stated to ask the nurse on the northside hallway if she has but they haven't requested the meds, so LVN #26 didn't think R #25 received her medication or G-tube feeding on 06/18/25. LVN #26 stated that anytime there's medications not available the physician is to be notified that the medication was not available and when the medication was not administered to R #25. G. On 06/18/25 at 9:50 AM during an interview with RN #27, she stated she fed R #25 through her G-tube and gave her medication at 9:42 AM on 06/18/25. RN #27 stated the order to feed R #25 is five times a day. RN #27 stated the times are scheduled and reference the MAR. The 10:00 AM the feeding was done, and RN #27 was not sure who fed resident at 8:00 AM feeding. RN #27 stated she documented in the MAR because she gave meds and feeding to R #25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 06/18/25 at 9:55 am, during an interview with the DON confirm the following: 1. An order to feed R #25 five times a day. 2. R #25 prefers females' staff to care for her. 3. Resident is expected to advocate for herself. 4. LVN #26 documented in R #25's MAR that he is doing R #25's medication administration and G-tube feedings and LVN #26 is overseeing her care when LVN #26 is not. This is not clear 5. Staff are expected to notify the provider if a resident refuses medication or if medication is not available. 6. Male staff working with R #25 are expected to follow up by asking female nurse if she administered R #25 medication and G-tube feeding. 7. Staff are expected to follow the order, notify the provider, and family of any changes with resident care. 8. Staff are expected to document all contact with the provider in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 3 (R #8, R #17, and R #25) of 3 (R #8, R #17, and R #25) residents reviewed for documentation accuracy when staff failed to do the following: 1. Document attempts to change R #8's brief. 2. Document attempts to shower/bathe R #8. 3. Document attempts to put sheets on R #8's mattress. 4. Document changing R #8's mattress. 5. Document R #17's fall on 04/05/25. 6. Document unavailable medication for R #25. These deficient practices have 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: R #8 A. On 06/16/25 at 10:00 AM, during a walk through of the facility, there was a strong smell of urine starting at room [ROOM NUMBER]. B. On 06/16/25 at 10:02 AM, during an interview, ADON #1 confirmed the smell of urine and indicated that it was coming from R #8's room. C. On 06/16/25 at 10:03 AM, during an observation of R #8's room the smell of urine became extremely strong. R #8 sat on his bed with nothing on, only a brief. The brief appeared to be extremely soiled and was dark in color. There were no sheets on R #8's mattress. D. On 06/17/25 at 8:50 AM, during an interview, the ADON said R #8 will go days without letting anyone change his brief. The ADON said R #8 will kick, throw things, and cuss at staff if he doesn't want to be changed. The ADON said R #8 does not like sheets on his bed. The ADON said R #8 will take the sheets off his bed if they put them on. The ADON said they are not able to shower R #8. The ADON said that when the resident is compliant with care, staff will do as much as they can for him. The DON said staff will reproach R #8 several times throughout the day to see if R #8 will allow them to change him, shower him, and put sheets on the resident's bed. The ADON said they have changed R #8's mattress several times due to the smell. The ADON said staff have to continue to ask the resident throughout the day if he will let them provide any care for him. E. Record review of R #8's medical record, no date, revealed the records did not contain documentation of the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The refusals to change R #8's brief throughout the day. 2. The reproach to shower/bathe R #8. 3. The attempts to put sheets on R #8's bed. 4. The changes of R #8's mattress. F. On 06/18/25 at 9:16 AM, during an interview, the ADON confirmed staff do not document all the attempts to shower/bathe, brief changes, and attempts to put sheets on R #8's bed. The ADON confirmed there was no documentation of the times that R #8's mattress has been changed. R #17 G. Record review of R #17's admission documents, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 had the following diagnoses: a. Muscle weakness. b. Lack of coordination. c. Abnormalities of gait and mobility. d. Difficulty in walking. H. Record review of R #17's progress note, dated 04/07/25, revealed the following: 1. R #17 had a fall on 04/05/25. 2. R #17 fell due to weakness and imbalance. I. Record review of R #17's entire medical record, no date, revealed staff did not document the following: 1. R #17's fall on 04/05/25. 2. Assessment data related to R #17 after her fall on 04/05/25. J. On 06/17/25 at 1:39 PM, during an interview, the DON confirmed the following: 1. R #17 fell on [DATE]. 2. Staff did not document in R #17's medical record that she fell on [DATE]. 3. Staff did not document an assessment of R #17 after she fell on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Staff did not document whether R #17's provider or R #17's family were notified after she fell on [DATE]. 5. Staff were expected to document when a resident falls, an assessment of the resident after the fall, provider notification and provider response, and notification of the resident's family. R #25 K. Record review of R #25's face sheet, no date, revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 diagnoses included the following: a. Hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure). b. Paroxysmal atrial fibrillation (a type of irregular heartbeat). c. Atherosclerotic heart disease of native coronary artery without angina pectoris (is caused by the buildup of plaque fats, cholesterol, and other substances in the arteries, leading to narrowed arteries and reduced blood flow). d. Chronic systolic (congestive) heart failure (systolic heart failure, the left ventricle of your heart, which pumps most of the blood, has become weak). e. Cardiomegaly (an enlarged heart is an indicator of a condition that puts a strain on your heart). f. Hypothyroidism, unspecified (thyroid gland doesn't make and release enough hormone into your bloodstream). L. Record review of R #25's physician orders, dated 6/11/24, revealed the following: 1. An order for amiodarone HCl oral tablet 200 mg give 200 mg via gastrostomy tube (G-tube a tube inserted through the belly that brings nutrition directly to the stomach) at bedtime for arrythmia (irregular heartbeat). 2. An order for Levothyroxine sodium oral tablet 112 mcg give 1 tablet via G-tube one time a day for hypothyroidism (thyroid gland doesn't make and release enough hormone into your bloodstream). M. Record review of R #25's MA dated June 2025, revealed the following: 1. Staff documented R #25's amiodarone code 9; (other see progress note effective) medication not available on 06/14/25 and 6/15/25. 2. Staff documented R #25's levothyroxine medication code 13; (medication not available effective) on 06/14/25 and 6/15/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. Record review of R #25's progress notes for 06/14/25 and 06/15/25 revealed staff did not notify the physician of the following medications not available: 1. R #25's amiodarone medication not available on the following date: a. 06/14/25, b. 06/15/25. 2. R #25's levothyroxine medication not available on the following dates: a. 06/14/25, b. 06/15/25. O. On 06/18/25 at 9:55 am, during an interview with the DON confirm staff are expected to notify the provider if medication is not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calibre Post Acute, LLC	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)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview, the facility failed to provide behavioral health training (training that helps staff recognize and respond to various behavioral and mental health issues that residents may present with) for 3 (CNA #8, CNA #9 and ADON #1) of 3 (CNA #8, CNA #9 and ADON #1) staff sampled for training. This deficient practice could likely result in residents not receiving the services necessary to attain or maintain their physical, mental, and psychosocial (involving both psychological and social aspects) well-being. The findings are: A. Record review of the facility's assessment dated 2024-2025, revealed the facility has 20 residents with behavioral health needs and 30 residents with mental illness diagnoses. B. Record review of staff training records revealed the following: 1. CNA #8 did not complete training for behavioral health. 2. CNA #9 did not complete training for behavioral health. 3. ADON #1 did not complete training for behavioral health. C. On 06/18/25 at 11:46 AM, during an interview, Human Resources confirmed CNA #8, CNA #9, and ADON #1 did not complete a training titled behavioral health.