

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 03/03/2026
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents remained free from physical restraints (any device used to prevent freedom of movement or action) unless staff used them to treat a specific medical condition (indication or characteristic of a medical, physical or psychological condition) as identified through an assessment for 1 (R #89) of 2 (R #3 and R #89) residents reviewed for physical restraints. This deficient practice could likely result in physical restraints being used for punishment or staff convenience; causing injury or unnecessarily restricting residents from freedom, movement, or activity. The findings are: A. Record review of R #89's admission Record, no date, revealed the following: 1. R #89 was admitted to the facility on [DATE]. 2. R #89 had the following diagnoses: a. Unspecified intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently). b. Depression (serious mood disorder characterized by persistent sadness, loss of interest in activities). c. Anxiety disorder (mental health condition characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life). B. Record review of R #89's progress note, dated 02/06/26, revealed the following: 1. On 02/06/25 at 8:45 AM, a CNA notified the ADON and DON that R #89 was restrained to the bed. 2. The ADON and DON observed R #89's arms restrained to the bed rails. 3. The ADON removed the restraints. 4. The ADON educated R #89's Developmental Disability Caregiver (DDC, provides daily living assistance, medical support, companionship, and advocacy for individuals with intellectual or developmental disabilities) that the facility does not allow restraints. C. On 03/02/26 at 3:15 PM, during an interview, ADON #1 stated the following: 1. On 02/06/26, one of the CNAs notified him that R #89 was tied to the bed. 2. ADON #1 notified the DON and they went to R #89's room. 3. R #89's DDC was lying on R #89's legs and R #89's arms were tied to the bed rails with blankets. 4. He untied the blankets from R #89's arms and assessed R #89 for injury. 5. R #89's DDC told him that he restrained R #89 because R #89 was trying to hit and kick him. R #89 said he was going to break the window. 6. ADON #1 explained to the DDC that the facility was restraint free and he was not allowed to restrain R #89. D. On 03/02/26 at 3:35 PM, during an interview, the DON stated the following: 1. On 02/06/26 at approximately 8:45 AM, she was notified by ADON #1 that a staff member observed R #89 restrained to the bed. 2. When she and ADON #1 arrived to R #89's room, they saw R #89's arms tied to the bed rails. 3. ADON #1 removed the restraints from R #89's arms. 4. ADON #1 told R #89's DDC that he cannot restrain R #89. 5. After this, she interviewed staff to see if anyone else had seen anything. 6. LPN #16 told her that on 02/06/26 around 6:30 AM he was notified that R #89 was restrained to the bed (a separate incident earlier in the morning). E. On 03/03/26 at 9:00 AM, during an interview, LPN #16 stated the following: 1. On 02/06/26 around 6:30 AM to 7:00 AM, he went into R #89's room there was a sheet tied around R #89's feet. 2. He untied the sheet from R #89's feet. 3. He educated R #89's DDC that the facility was a restraint free facility and he cannot restrain R #89. F. On 03/03/26 at 9:59 AM, during an interview, the DON confirmed the following: 1. The facility does not allow residents to be restrained. 2. R #89 should not have been restrained. G. Record review of facility restraint policy, dated 09/30/23, revealed Physical restraints shall only be used for the safety and wellbeing of the (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse to the State Survey Agency for 1 (R #89) of 2 (R #3 and R #89) residents reviewed for physical restraints (any device used to prevent freedom of movement or action). If the facility fails to report incidents of possible abuse to the State Agency, then the State Agency is unable to ensure residents have a safe environment. The findings are: A. Record review of R #89's progress note, dated 02/06/26, revealed the following: 1. On 02/06/25 at 8:45 AM, a facility staff member notified the ADON (the documentation did not specify which ADON) and the DON that R #89 was restrained to the bed. 2. The ADON and DON observed R #89's arms restrained to the bed rails. 3. The ADON removed the restraints from R #89's arms. 4. The ADON educated R #89's developmental disability caregiver (DDC, provides daily living assistance, medical support, companionship, and advocacy for individuals with intellectual or developmental disabilities) that the facility does not allow restraints. B. On 03/02/26 at 3:35 PM, during an interview, the DON stated the following: 1. On 02/06/26 at approximately 08:45 AM, she was notified by ADON #1 that a staff member observed R #89 restrained to the bed. 2. ADON #1 and the DON went to R #89's room and saw R #89's arms tied to the bed rails with blankets. 3. ADON #1 removed the restraints from R #89's arms. 4. ADON #1 educated R #89's DDC that he cannot restrain R #89. 5. After this, she interviewed staff to determine whether anyone else had witnessed the incident. 6. LPN #16 told her that on 02/06/26 around 6:30 AM he saw R #89 restrained to the bed and had educated R #89's DDC that he could not restrain R #89. C. On 03/03/26 at 9:00 AM, during an interview, LPN #16 stated the following: 1. On 02/06/26 around 6:30 AM to 7:00 AM, he went into R #89's room he went into R #89's room and observed a sheet tied around R #89's feet. 2. He said R #89's DDC said R #89 was trying to kick the window, so he tied his feet. 3. He untied the sheet from R #89's feet. 4. He educated R #89's DDC that the facility was a restraint free facility and he cannot restrain R #89. 5. R #89's DDC verbalized understanding that he cannot restrain R #89. D. Record review of the incident report submitted to the state agency, dated 02/06/26, revealed the following: 1. On 02/06/26 at 8:45 AM, R #89's arms were restrained by the DDC. 2. R #89's DDC was educated that the facility has a no restraint policy (staff are not allowed to use restraints). 3. Staff did not document that R #89 had been restrained by R #89's DDC on 02/06/26 between 6:30 AM and 7:00 AM. E. Record review of the follow-up report submitted to the state agency, dated 02/09/26, revealed staff did not document that during the investigation the DON was informed that R #89 had also been restrained by R #89's DDC on 02/06/26 between 6:30 AM and 7:00 AM. F. On 03/03/26 at 9:38 AM, during an interview, the Administrator confirmed the following: 1. LPN #16 did not notify administration when he found R #89 restrained by his DDC between 6:30 AM and 7:00 AM. 2. Staff were expected to notify administration immediately of any concerns of abuse 3. The facility did not notify the state agency that R #89 had been restrained in the facility by his DDC on 02/06/26 between 6:30 AM and 7:00 AM. 4. The facility was expected to report all allegations of abuse to the state agency within two (2) hours of the incident.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement an effective training program for the Developmental Disability Caregivers (DDC, provides daily living assistance, medical support, companionship, and advocacy for individuals with intellectual or developmental disabilities) for 3 (DDC #1, DDC #2, and DDC #3) of 3 (DDC #1, DDC #2, and DDC #3) DDC's who provided care for R #89. If the DDC staff are not trained, then they could likely not have the knowledge to safely care for residents in the facility. The findings are: A. Record review of R #89's admission Record, no date revealed the following: 1. R #89 was admitted to the facility on [DATE]. 2. R #89 had a diagnosis of unspecified intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently). B. Record review of R #89's progress notes revealed the following: 1. On 02/05/26 at 11:47 PM, R #89's DDC (the record did not specify which DDC) was at his bedside. 2. On 02/06/26 at 12:53 AM, R #89's DDC was present (the record did not specify which DDC). 3. On 02/06/26 at 5:52 AM, R #89's DDC was present. 4. On 02/06/26 at 9:33 AM, staff documented that at 8:45 AM, the DON and ADON witnessed R #89 with his arms tied to the bed rails. The ADON educated DDC #1 that restraints were not allowed in the facility, and DDC #1 was relieved by DDC #2. C. On 03/03/26 at 12:17 PM, during an interview, the DON stated the following: 1. R #89 would have DDCs who stayed with him around the clock. 2. She understood that the DDCs were supposed to provide R #89 with the same services they provided in his home, such as feeding, redirection, and companionship. D. On 03/03/26 at 12:42 PM, during an interview, ADON #1 stated the following: 1. DDC #2 was with R #89 when he first arrived. 2. DDC #3 relieved DDC #2 on 02/05/26 but he was not sure what time. 3. DDC #1 relieved DDC #3 sometime during the night shift between 02/05/26 and 02/06/26. 4. DDC #2 relieved DDC #1 at approximately 9:30 AM on 02/06/26. E. On 03/03/26 at 12:50 PM, during an interview, the DON confirmed the following: 1. DDC #1, DDC #2, and DDC #3 did not receive any training from the facility regarding facility policies and expectations. 2. She assumed the DDCs' employer required the same training for the DDCs as the facility required for its staff. 3. She was not sure what training DDC #1, DDC #2, or DDC #3 had received. 4. The facility did not provide DDC #1, DDC #2, or DDC #3 any training regarding its policies and expectations before they assisted R #89 in the facility.</p>		