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	11/06/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49313 Based on record review and interview, the facility failed to notify the resident and the resident's representative of a transfer in writing for 1 (R #77) of 2 (R #77 and R #94) residents sampled for hospitalization s when they failed to: 1. Notify the resident or the resident's representative of the transfers to the hospital in writing and in a language and manner they understand. 2. Contents of the notice include the following: -The name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman on the transfer notification form. -Statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 3. Send a written copy of the Transfer Notices to the Ombudsman. These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer, and their rights to advocate and make informed decision regarding their healthcare. The findings are: A. On 10/28/24 at 3:28 PM, during an interview with R #77's representative, she stated the following: 1. R #77 was transferred to the hospital, three times since admission, one time was on 10/27/24. 2. She could not remember the dates of the other two hospital transfers. 3. Staff did not give R #77 or her representative paperwork before R #77 was transferred to the hospital (all three times) or when R #77 returned to the facility. B. Record review of R #77's progress note, dated 09/23/24, revealed R #77 was transferred to the hospital on 09/23/24. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review of R #77's transfer notice, dated 09/23/24, revealed the following: 1. Staff did not document that a copy of the transfer notice was provided to the resident or their representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 3. Staff did not document a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 4. Staff did not document that a written copy of the Transfer Notice was sent to the Office of the State Long-Term Care Ombudsman. D. Record review of R #77's progress note dated 09/25/24, revealed R #77 was transferred to the hospital on 09/25/24. E. Record review of R #77's transfer notice, dated 09/25/24, revealed the following: 1. Staff did not document that a copy of the transfer notice was provided to the resident or their representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 3. Staff did not document a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 4. Staff did not document that a written copy of the Transfer Notice was sent to the Office of the State Long-Term Care Ombudsman. F. Record review of R #77's progress note, dated 10/28/24, revealed R #77 was transferred to the hospital on 10/27/24. G. Record review of R #77's entire medical record, revealed that the medical record did not have a transfer notification when the resident was transferred to the hospital on 10/27/24 H. On 11/06/24 at 9:27 AM, during an interview with LPN #16, stated the following: 1. Nursing staff are expected to complete a transfer notice prior to sending a resident to the hospital. 2. Staff give the transfer notice to the paramedics along with other documentation. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Staff do not give a copy of the transfer notice to the resident or their representative. 4. She confirmed that the transfer notices does not have information for how to contact the Office of the State Long-Term Care Ombudsman. 5. She confirmed that the transfer notices does not have a statement of the resident's appeal rights. 6. She confirmed staff did not complete a transfer notice for R #77's transfer to the hospital on 10/27/24. I. On 11/06/24 at 12:05 PM, during an interview with the Social Services Director, stated the following: 1. Nurses are expected to complete transfer notifications at the time of a resident's transfer to the hospital or another facility. 2. She sends a report weekly to the Ombudsman that includes who was transferred from the facility. 3. She does not send a written copy of the transfer notice to the Ombudsman. 4. She confirmed that the facility transfer notices does not include information for how the resident or their representative can appeal a transfer. 5. She confirmed that the facility transfer notices does not include information for how the resident or their representative can contact the Ombudsman. J. On 11/06/24 at 1:03 PM, during an interview with the DON, stated the following: 1. Staff are not expected to give a transfer notice to the resident or their representative prior to being transferred to the hospital. 2. Staff are expected to contact the resident's POA to notify about the resident being transferred to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47510 Based on record review and interview, the facility failed to ensure residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 2 (R #77 and R #94) of 2 (R #77 and R #94) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are: R #77 A. On 10/28/24 at 3:28 PM, during an interview with R #77's family member (resident representative), she stated the following : 1. R #77 was transferred to the hospital three times since admission, one time was on 10/27/24. 2. She could not remember the dates of the other two hospital transfers. 3. Staff did not give R #77 or her representative a bed hold policy notification before R #77 was transferred to the hospital (all three times) or when R #77 returned to the facility. B. Record review of R #77's progress note, dated 09/23/24, revealed R #77 was transferred to the hospital on 09/23/24. C. Record review of R #77's bed hold notice, dated 09/23/24, revealed the following: 1. Staff did not document how many days a bed would be held for the resident. 2. Staff documented on the resident signature line that R #77's daughter was notified about the bed hold notice. 3. Staff did not document that the written Bed Hold Notification was provided to the resident. 4. Staff did not document that the written Bed Hold Notification form was provided to the resident's representative. D. Record review of R #77's progress note, dated 09/25/24, revealed R #77 was transferred to the hospital on 09/25/24. E. Record review of R #77's bed hold notice, dated 09/25/24, revealed the following: 1. Staff did not document who was notified about the Bed Hold Notification. 2. The form was blank on the resident signature line. 3. Staff did not document that the written Bed Hold Notification was provided to the resident. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Staff did not document that the written Bed Hold Notification form was provided to the resident's family. F. Record review of R #77's progress note, dated 10/28/24, revealed R #77 was transferred to the hospital on 10/27/24. G. Record review of R #77's entire medical record, revealed the medical record did not have a Bed Hold Notification when R #77 was transferred to the hospital on 10/27/24. H. On 11/06/24 at 9:27 AM, during an interview with LPN #16, the following was stated: 1. Nurses complete a Bed Hold Policy Notification when a resident is transferred to the hospital. 2. If the resident is alert at the time of transfer, the nurses discuss the Bed Hold Policy and will have them sign the Bed Hold Policy Notification 3. If the resident is unable to sign the Bed Hold Policy Notification at the time of transfer, the nurses give the Bed Hold Policy Notification to Social Services to contact the resident's family within 24 hours. 4. LPN #16 confirmed staff did not complete a Bed Hold Policy Notification for R #77 prior to her transfer to the hospital on 10/27/24. I. On 11/06/24 at 12:05 PM, during an interview with the Social Services Director, the following was confirmed: 1. Nurses complete Bed Hold Notifications prior to residents being transferred to the hospital. 2. The nurses have the resident or the resident representative sign the Bed Hold Policy Notification at the time of the transfer. 3. If the resident is unable to sign and a resident representative is not present at the time of transfer, the nurses call the resident's representative to notify them about the Bed Hold Policy. 4. The nurses send a copy of the Bed Hold Policy with the resident at the time of the transfer. 5. She does not contact the resident's family to sign the Bed Hold Policy Notification. 6. She does not send a copy of the Bed Hold Policy Notification to the resident's representative. 7. She confirmed R #77's Bed Hold Policy Notification, dated 09/23/24, staff did not document the number of bed hold days R #77 had remaining. 8. She confirmed R #77's Bed Hold Policy Notification, dated 09/25/24, the resident or their representative did not sign the form. 9. She confirmed staff did not complete a Bed Hold Policy Notification for R #77's transfer to the hospital on 10/27/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 11/06/24 at 1:03 PM, during an interview with the DON, stated that nursing staff would not be expected to give a Bed Hold Policy Notification to the resident or their representative prior to being transferred to the hospital (contradicting finding H and finding I). R #94 K. Record review of R #94's Discharge summary revealed R #94 was transferred to the hospital on 08/05/24 due to hardware exposure (a situation where orthopedic hardware, such as screws, plates, or replacement joints, is exposed). L. Record review of R # 94's bed hold notice and authorization dated 08/05/24, revealed the following: 1. The number of days the bed would be held was not documented. 2. The date that notice was provided to the resident or resident representative was not documented. M. On 11/05/24 at 1:02 PM, during an interview, the DON said that the bed-hold notice should have the days that the bed will be held so that the residents know how many days they have and it should be documented when it was provided to the resident or resident representative. 49313

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure a comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff that reflects a resident's functional capabilities) was completed for 2 (R #82 and R #88) of 3 (R #5, R #82, and R #88) residents reviewed for resident assessments. This deficient practice could likely result in in the facility receiving monies they are not entitled to and possible delays in transitions to a new setting. The findings are: R #82 A. Record review of R #82's medical record revealed a discharge date of [DATE]. B. Record review of R #82's medical record revealed staff did not complete a Discharge MDS assessment until 11/01/24. C. On 011/06/24 at 4:10 PM, during interview, MDS Coordinator #1 confirmed R #82's Discharge MDS assessment was not completed upon discharge. R #88 D. Record review of R #88's medical record revealed a discharge date of [DATE]. E. Record review of R #88's medical record revealed staff did not complete a Discharge MDS assessment until 11/01/24. F. On 011/06/24 at 4:10 PM, during interview, MDS Coordinator #1 confirmed R #88's Discharge MDS assessment was not completed upon discharge.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set Assessment (MDS, part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment) was accurate for 5 (R #33, R #36, R #48, R #84, and R #85) of 6 (R #5, R #33, R #36, R #48, R #84, and R #85) residents review for MDS assessment accuracy. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: R #33 A. Record review of R #33's admission record, no date, revealed the following: 1. R #33 was admitted to the facility on [DATE]. 2. R #33 had the following diagnoses: a. Type 2 diabetes mellitus (a long-term condition in which the body is unable to make enough insulin to control blood sugar). b. Difficulty in walking. c. Muscle weakness. d. Peripheral vascular disease (a chronic condition that occurs when blood vessels outside of the heart and brain narrow or become blocked). e. Edema (swelling caused by too much fluid trapped in the body's tissues). B. Record review of R #33's progress note, dated 10/03/24, revealed R #33 had a partial avulsed right great (largest toe) toenail (a common treatment for ingrown toenails that are painful or recur often) and a wound to the right heel (identified in finding C as a diabetic ulcer). C. Record review of R #33's physician's order, multiple dates, revealed the following: 1. Order dated 10/03/24 and discontinued on 10/29/24, for wound care for an ulceration (open sore that can develop on the skin) to R #33's right heel. 2. Order dated 10/03/24 and discontinued on 10/29/24, for wound care to R #33's right great toe. 3. New wound care orders dated 10/29/24, for the diabetic ulcer to R #33's right heel. D. Record review of R #33's quarterly Minimum Data Set assessment dated [DATE], revealed the following: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Section M1040: Other Ulcers, Wounds and Skin Problems. a. Staff did not document that R #33 had any diabetic foot ulcers to the right heel. b. Staff did not document that R #33 had any other open lesions on the foot (including the wound to the right great toe). 2. Section N0350: Insulin (injectable medication that helps control blood sugar levels in people with diabetes). Staff documented that R #33 received insulin seven times in the last seven days. 3. Section N0415: High-Risk Drug Classes (Medications that can cause significant harm to residents if used incorrectly). Staff did not document that resident received high-risk medication insulin. E. On 11/05/24 at 1:12 PM, during an interview with MDS Coordinator # 2, the following was confirmed: 1. R #33 had a diabetic ulcer to her right heel. 2. R #33 had a wound to her right great toe. 3. R #33's Quarterly MDS Assessment, dated 10/20/24, did not include R #33's wound on her right heel and her wound on her right great toe. 4. The MDS Assessment should have included the wounds to R #33's right heel and right great toe. F. On 11/05/24 at 1:50 PM, during an interview MDS Coordinator #1, she confirmed section N0415 of the MDS assessment should have been updated to document R #33 was on insulin which is considered a high-risk medication. R #36 G. On 10/29/24 at 9:06 AM, during an interview, R #36 said the facility does not give her the food she is supposed to eat because she is a diabetic. H. Record review of R #36's physician orders dated 09/28/24, revealed R #36 had an order for Humalog Injection Solution (a fast-acting insulin) 100 unit/ML. I. Record review of R #36's medical record, no date, revealed R #36 did not have a diagnosis of diabetes. J. Record review of R #36's MDS assessment dated [DATE], revealed R #36 did not have a diagnosis of diabetes, or a diabetic meal/ preference. K. On 10/31/24 at 10:24 AM, during an interview, LPN #8 confirmed R #36 was a diabetic and had an order for insulin. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. On 10/31/24 at 11:47 AM, during an interview, the DON said R #36 is a diabetic. The DON confirmed that R #36 was taking insulin. The DON confirmed that R #36's quarterly MDS dated [DATE] does not document that she is a diabetic. The DON confirmed that the MDS should document R #36's current diagnosis to ensure she is receiving the care she needs. R #48 M. Record review of R #48's admission record, no date, revealed the following: 1. R #48 was admitted to the facility on [DATE]. 2. R #33 had the following diagnoses: a. Hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death) affecting right dominant side (side of the body that is more active). b. Hypertensive heart disease (complication of high blood pressure that affect the heart) with heart failure (chronic condition in which the heart doesn't pump blood as well as it should). N. Record review of R #48's physician's orders revealed the following: 1. Order dated 12/21/23; Eliquis Oral Tablet (anticoagulant medication used to help prevent blood clots from forming), give 5 mg by mouth two times a day for atrial fibrillation (condition in which the heart beats rapidly irregularly reducing the ability to pump blood properly increasing the chance of blood clot formation). 2. Order dated 03/11/24; Miralax oral powder (laxative medication which softens stool and may naturally stimulate the colon [tube shaped organ in the digestive system that removes waste from the body] to contract) 17 grams/scoop, give 1 scoop by mouth in the morning for constipation (condition in which a person has uncomfortable or infrequent bowel movements). 3. Order dated 04/04/24; Lactulose Oral Solution (laxative medication used to treat chronic constipation), give 30 ml by mouth two times a day for constipation. 4. Order dated 04/12/24; Fleet Enema (liquid laxative solution inserted directly into the rectum to help induce a bowel movement) insert 1 application rectally every 24 hours as needed for Constipation. 5. Order dated 07/05/24; Sennosides-Docusate Sodium Oral Tablet (combination medication of stimulant laxative and stool softener used to treat constipation) 8.6-50 mg, give 1 tablet by mouth two times a day for constipation. O. Record review of R #48's Annual Minimum Data Set assessment dated [DATE], revealed the following: 1. Section H0600: Bowel Patterns, staff documented No to the question was constipation present. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. Record review of R #48's Quarterly Minimum Data Set assessment dated [DATE], revealed Section N0415 High-Risk Drug Classes (medications that can cause significant harm to residents if used incorrectly), staff did not document that R #48 was taking an anticoagulant which is a high-risk medication. Q. On 11/05/24 at 1:53 PM, during an interview with MDS Coordinator # 1, the following was confirmed: 1. R #48 takes multiple medications to treat constipation. 2 Section H0600 was inaccurate and should have been answered Yes because R #48 was routinely receiving medications to treat constipation. R. On 11/06/24 at 1:38 PM, during an interview with MDS Coordinator # 2, the following was confirmed: 1. R #48 does take an anticoagulant medication daily. 2. Staff did not document that resident was receiving an anticoagulant which is a high-risk medication. R #84 S. On 10/28/24 at 1:50 PM, during an interview with R #84, stated the following: 1. He told staff that he had broken teeth on the top and bottom of his right side of his mouth. 2. Staff scheduled a dental appointment for him, but it was on the day his parents visit him. 3. He was unsure if staff had rescheduled his dental appointment. T. Record review of R #84's admission record, no date, revealed the following: 1. R #84 was admitted to the facility on [DATE]. 2. R #84 had the following diagnoses: a. Multiple sclerosis (a chronic disease that affects the central nervous system, including the brain and spinal cord) b. Need for assistance with personal care c. Muscle weakness U. Record review of R #84's physician progress note, dated 08/20/24, revealed the following: 1. R #84 reported a broken lower molar to the provider. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/25/24, -10/27/24, -10/28/24, -10/29/24, -10/30/24, -11/03/24. W. Record review of R #84's Quarterly MDS assessment Section L0200: Dental, dated 10/21/24, revealed staff did not document R #84 had mouth or facial pain. X. On 11/05/24 at 1:19 PM, during an interview with MDS Coordinator # 2, she confirmed the following: 1. R #84 received pain medication multiple times for dental pain during the time of the MDS Assessment. 2. Staff did not document on R #84's Quarterly MDS Assessment, dated 10/21/24, R #84 had mouth or facial pain. 3. Staff should have documented that R #84 had mouth or facial pain on the Quarterly MDS Assessment, dated 10/21/24. R #85 Y. On 10/28/24 at 1:12 PM, during an observation and interview with R #85, the following was revealed: 1. A foley catheter (a flexible tube that drains urine from the bladder into a collection bag) collection bag hung from R #85's bed. 2. R #85 stated, she had the foley catheter for about three months. 3. R #85 stated, she asked the doctor if they could remove her foley catheter. 4. She stated the doctor told her they could remove her foley catheter when she was more active. Z. Record review of R #85's admission record, no date, revealed the following: 1. R #85 was admitted to the facility on [DATE]. 2. R #85 had the following diagnoses: (continued on next page)

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	325039	A. Building B. Wing	11/06/2024

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Urinary tract infection (a bacterial infection that affects the urinary tract, which includes the bladder, uretha, and kidneys) b. Bladder disorder, unspecified (urinary bladder disease includes urinary bladder inflammation such as cystitis, bladder rupture and bladder obstruction) AA. Record review of R #85's physician's order, dated 09/03/24, revealed an order to clamp R #85's foley catheter for 15 minutes every 4 hours for a total of 24 hours for bladder training (a behavioral technique that can help people regain bladder control), then remove the foley catheter. BB. Record review of R #85's Treatment Administration Record, dated September 2024, revealed the following: 1. On 09/03/24 at 4:00 PM, staff documented, staff completed the clamp and release of R #85's foley catheter for bladder training. 2. On 09/03/24 at 8:00 PM, staff documented, staff completed the clamp and release of R #85's foley catheter for bladder training. 3. On 09/04/24 at 12:00 AM, staff documented, staff completed the clamp and release of R #85's foley catheter for bladder training. 4. On 09/04/24 at 4:00 AM, staff documented, staff completed the clamp and release of R #85's foley catheter for bladder training. 5. On 09/04/24 at 8:00 AM, staff documented staff completed the clamp and release of R #85's foley catheter for bladder training. 6. On 09/04/24 at 12:00 PM, staff documented staff completed the clamp and release of R #85's foley catheter for bladder training. CC. Record review of R #85's Admission MDS Assessment, Section H0200: Urinary Toileting Program, dated 09/05/24, revealed staff documented R #85 had not had a trial of a toileting program since admission to the facility. DD. On 11/05/24 at 1:07 PM, during an interview with MDS Coordinator #2, the following was confirmed: 1. R #85 had an order dated 09/03/24, for bladder training. 2. On R #85's Admission MDS assessment dated [DATE], staff documented R #85 did not have a trial in a toileting program. 3. Staff should have documented R #85 participated in a toileting program. 47510 49313

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 2 (R #48 and R #77) of 6 (R #5, R #41, R #48, R #60, R #77 and R #81) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #48 A. Record review of R #48's admission record, no date, revealed the following: 1. R #48 was admitted to the facility on [DATE]. 2. Diagnosis of hypertensive heart disease with heart failure (condition that occurs when chronic high blood pressure damages the heart and prevents the heart from pumping blood effectively to the rest of the body). B. Record review of R #48's physician's orders revealed: 1. Order dated 12/21/23; Furosemide (diuretic medication used to treat fluid retention and swelling) oral tablet, give 40 mg by mouth one time a day for congestive heart failure (CHF; chronic condition in which the heart does not pump blood as well as it should which can cause fluid retention, shortness of breath and swelling of legs) C. Record review of R #48's Quarterly Minimum Data Set (MDS, federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes), dated 09/19/24, revealed section N0415 High-Risk Drug Classes (medications that can cause significant harm to residents if used incorrectly), staff documented R #48 took furosemide which is a high-risk medication. D. Record review of R #48's care plan, dated 05/29/24, revealed staff did not document that R #48 had a diagnosis of heart failure and was taking the high-risk medication furosemide. E. On 11/05/24 at 2:03 PM, during an interview with MDS Coordinator #2, she confirmed R #48's care plan dated 05/29/24 did not include hypertensive heart disease with heart failure and R #48 took high risk medication furosemide. R #77 F. Record review of R #77's Admission Record, no date, revealed the following: 1. R #77 was admitted to the facility on [DATE]. 2. R #77 had the following diagnoses: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Metabolic encephalopathy (a group of neurological disorders that occur when the brain is affected by a chemical imbalance in the blood). b. Type 2 diabetes mellitus (a long-term condition in which the body is unable to make enough insulin to control blood sugar) with hyperglycemia (high blood sugar). c. Acute kidney failure (a sudden decline in kidney function that occurs within a week). G. Record review of R #77's progress note, dated 09/19/24, revealed R #77 arrived at the facility with a foley catheter (a flexible tube that drains urine from the bladder into a collection bag). H. Record review of R #77's physician order, dated 09/22/24, revealed an order to change foley catheter monthly for history of urinary retention (a condition that makes it difficult or impossible to empty the bladder) and chronic (long term) foley catheter use since 06/2023. I. Record review of R #77's Admission Minimum Data Set Assessment, dated 10/09/24, revealed R #77 had an foley catheter (medical device that drains urine from the bladder). J. Record review of R #77's care plan, dated 10/02/24, revealed staff did not document that R #77 had a diagnosis of urinary retention and R #77 had a foley catheter. K. On 11/05/24 at 1:16 PM, during an interview with MDS Coordinator #2, she confirmed the following: 1. R #77's care plan did not include R #77 had urinary retention and a foley catheter. 2. Staff should have documented on R #77's care plan that she had a foley catheter. 49313

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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** 47510 Based on record review and interview, the facility failed to ensure care plans were reviewed and revised for 6 (R #26, R #28, R #46, R #59, R #64, and R #85) of 6 (R #26, R #28, R #46, R #59, R #64, and R #85) residents reviewed for care plans when they failed to: 1. Have an Interdisciplinary Team Meeting (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) within seven days after the completion of the Admission Minimum Data Set assessment (MDS, part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment) for R #85. 2. Revise the care plan with the most current resident information for R #26, R #28, R #46, R #59, and R #64. These deficient practices 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: Care Plan Timing R #85 A. Record review of R #85's admission record, no date, revealed R #85 was admitted to the facility on [DATE]. B. On 10/28/24 at 1:10 PM, during an interview with R #85, she revealed she had not been invited to a care plan meeting since she was first admitted to the facility. C. Record review of R #85's Admission MDS assessment, dated 09/03/24, revealed staff completed R #85's Admission MDS Assessment on 09/05/24. D. Record review of R #85's progress notes, dated 08/27/24 through 11/05/24, revealed the following: 1. R #85 had an IDT meeting on 08/28/24. 2. Staff did not complete an IDT meeting after R #85's admission MDS assessment was completed on 09/05/24. Care Plan Revisions R #26 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #26's admission documents, no date, revealed the following: 1. R #26 was admitted to the facility on [DATE]. 2. R #26 had a diagnosis of Depression (a mental health condition that can affect anyone, causing a persistent low mood and loss of interest in activities). F. Record review of R #26's physician's orders, multiple dates, revealed the following: 1. An order, dated 08/19/24, for Prozac (an antidepressant medication used to treat depression, obsessive-compulsive disorder (OCD), bulimia nervosa, and panic disorder) 20 mg, give 2 tablets by mouth once a day for depression. 2. An order dated 08/21/24 and discontinued 10/21/24, for Olanzapine (an antipsychotic medication used to treat mental disorders, including schizophrenia and bipolar disorder) 2.5 milligrams (mg, unit of measure), give one tablet at bed time for Major Depressive Disorder (MDD, a serious mental health condition that involves a persistent low mood and loss of interest in activities). 3. An order, dated 10/22/24, for Olanzapine 2.5 mg, give 2 tablets one time a day for MDD related to depression. G. Record review of R #26's care plan, dated 06/18/24, revealed the following: 1. Staff documented that R #26 feels sad. 2. Staff did not revise R #26's care plan to include that R #26 had a diagnosis of Depression. 3. Staff did not revise R 26's care plan to include that R #26 takes antidepressant medication. 4. Staff did not revise R #26's care plan to include that R #26 takes antipsychotic medication. H. On 11/05/24 at 1:25 PM, during an interview with MDS Coordinator #2, the following was confirmed: 1. R #26 had a diagnosis of depression. 2. R #26 had orders for antidepressant medication. 3. R #26 had orders for antipsychotic medications. 4. Staff did not document in R #26's care plan that R #26 had a diagnosis of depression or that R #26 had orders for antidepressant and antipsychotic medication. 5. Staff should have documented R #26's diagnosis of depression and orders for antidepressant and antipsychotic medication in R #26's care plan. R #28 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. On 10/29/24 at 2:17 PM, during an interview, R #28 said that she did not like the food at the facility and that is why her family decided she needed a feeding tube (flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract). J. Record review of R #28's physician's orders dated 06/12/24 revealed enteral feed (a method of providing nutrients and fluids to a patient through their digestive system) Isosource 250 ml of formula four times a day as tolerated. K. Record review or R #28's progress note dated 09/28/24, revealed R #28 refused her Isosource 250 ml feeding for the evening. L. On 11/05/24 at 12:56 PM, during an interview, the DON said that R #28's refusals should be documented on the care plan for continuity of care. The DON confirmed that R #28's refusals were not care planned for. R #46 M. Record review of R #46's admission documents, no date, revealed R #46 was admitted to the facility on [DATE]. N. Record review of the facility list of residents that smoke, no date, revealed R #46 was a smoker. O. On 10/29/24 at 1:00 PM, during an interview with R #46, he revealed the following: 1. He goes outside to smoke twice a day. 2. He smoked without supervision. P. Record review of R #46's care plan, dated 10/07/24, revealed the following: 1. Staff did not document that R #46 was a smoker. 2. Staff did not document interventions in place to ensure R #46 was safe when smoking. Q. On 11/04/24 at 8:51 AM, during in interview with the Activities Director, the following was revealed: 1. Residents who are cognitive are able to smoke on their own. 2. The nurse completes the smoking assessments to determine the safety of residents to smoke independently. 3. If someone requires assistance, the nurses notify her and her or one of the activities staff will go with the resident to smoke. 4. Resident smoking equipment is stored in lock boxes that she keeps in her office. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Residents have specified smoke break times. 6. R #46 was independent with smoking. 7. Staff did not document on R #46's care plan that he smoked or any interventions in place to keep him safe. R #59 R. On 10/28/24 at 3:56 PM, during an interview, R #59's daughter said R #59 goes to the bathroom on her own, but sometimes has an accident. S. Record review of R #59's MDS assessment dated [DATE], revealed R #59 was occasionally incontinent (having trouble controlling your bladder or bowels occasionally or mildly). T. Record review of R 59's care plan dated 08/07/24, revealed R #59 is continent of bowel and bladder. U. On 11/05/24 at 12:49 PM, during an interview, the DON confirmed R #59's occasional incontinence was not care planned for. The DON said that R #59's care plan should document the resident's current condition so that her care is consistent with R #59's needs. R #64 V. Record review of R #64's admission documents, no date, revealed R #6 was admitted to the facility on [DATE]. W. Record review of the facility list of residents that smoke, no date, revealed R #64 was a smoker. X. On 10/28/24 at 2:57 PM, during an interview with R #64, the following was revealed: 1. He had an incident where he was smoking a cigarette in his room at night. 2. The facility took his smoking supplies away. 3. He used to be able to smoke whenever he wanted. 4. The facility has set specific times for smoking. 5. The facility has started locking up smoking equipment and only lets them have them at the set times. Y. Record review of R #64's progress note, dated 09/07/24, revealed the following: 1. R #64 was found smoking in his room while using oxygen on 09/06/24. 2. Staff found two lighters, five vape pens, and three empty packs of cigarettes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Z. Record review of R #64's care plan, dated 01/26/24, revealed the following: 1. R #64 was able to keep his cigarettes and lighter in his room. 2. R #64 was able to smoke independently. 3. R #64's care plan was not revised to include the incident of resident smoking in his room on 09/06/24. 4. R #64's care plan was not revised to include that the facility had set smoking times. 5. R #64's care plan was not revised to include that R #64's smoking supplies were being secured by staff in a lockbox. AA. On 11/05/24 at 1:21 PM, during an interview with MDS Coordinator # 2, the following was confirmed: 1. R #64 was caught smoking in his room on 09/06/24. 2. R #64's care plan was not revised to include the incident that occurred on 09/06/24. 3. R #64's care plan was not revised to include that the facility secures his smoking supplies in lockboxes. 4. Staff should have revised R #64's care plan to include the incident that occurred on 09/06/24. 5. Staff should have revised R #64's care plan to include that the facility was securing his smoking supplies. BB. On 11/06/24 at 1:06 PM, during an interview with the DON, she confirmed the following: 1. Staff were expected to document on the resident's care plan that they were a smoker. 2. Staff were expected to document any interventions in place to keep them safe while smoking. 49313

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 41755 Based on record review and interview, the facility failed to provide services that meet professional standards of practice for 1 (R #81) of 5 (R #52, R #59, R #60, R #81 and R #251) residents reviewed for physician's orders when staff failed to: 1. Obtain a Dexcom (continuous glucose monitoring system that tracks glucose levels in the body, without requiring fingersticks [use of lancet to draw blood from the finger]) as ordered by the physician. 2. Ensure R #81 received weekly Trulicity (injectable medication used to treat diabetes by assisting the body to use the insulin it is already making) injections. These deficient practices could likely result in worsening of medical conditions. The findings are: A. On 10/29/24 at 09:27 AM, during an interview, R #81 stated she had not had her Dexcom to monitor her sugar levels in two months. She stated she now must get a fingerstick to check her glucose levels four times a day. B. Record review of R #81's physician's orders revealed the following: 1. Order dated 03/30/24; Trulicity Solution 3 mg/0.5 ml, inject 3 mg subcutaneously (under the skin) one time a day every Sunday for diabetes mellitus type 2 (condition in which the body can't use sugar properly, leading to high blood sugar levels). 2. Order dated 05/14/24; Dexcom sensor, apply to right arm topically before meals and at bedtime for diabetes mellitus. C. Record review of R # 81's medication administration record (MAR; form used to document administration of medication and treatments) for July 2024, revealed: 1. Dexcom was marked as not administered, see progress notes on the following dates 07/03/24, 07/04/24, 07/08/24, 07/09/24, 07/13/24, 07/17/24, 07/18/24, 07/20/24, 07/21/24, 07/22/24, 07/23/24, 07/26/24, 07/27/24, 07/28/24, 07/29/24, and 07/31/24. 2. Trulicity was marked as not administered, see progress notes on the following dates 07/14/24 and 07/28/24. D. Record review of R # 81's MAR for August 2024, revealed the following: 1. Dexcom was marked as not administered, see progress notes on the following dates 08/01/24 through 08/17/24 and 08/19/24. 2. Trulicity was marked as not administered, see progress notes on the following dates 08/04/24, 08/11/24, 08/18/24, and 08/25/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R # 81's MAR for September 2024, revealed the following: 1. Dexcom was marked as not administered, see progress notes on the following dates 09/05/24 and 09/06/24. 2. Trulicity was marked as not administered, see progress notes on the following dates 09/01/24, 09/08/24, 09/15/24, 09/22/24 and 09/29/24. F. Record review of R # 81's MAR for October 2024, revealed the following: 1. Dexcom was marked as not administered, see progress notes on the following dates 10/02/24 through 10/30/24. 2. Trulicity was marked as not administered, see progress notes on the following dates 10/06/24, 10/13/24, 10/20/25, and 10/27/24. G. Record review of R # 81's progress notes from July 2024 through October 2024, revealed the following: 1. 07/03/24 and 07/04/24 nursing staff documented, Dexcom not available. 2. 07/08/24 nursing staff documented, Dexcom not available. 3. 07/09/24 nursing staff documented, Dexcom supplies on order. 4. 07/17/24 through 07/19/24 nursing staff documented, Dexcom not available. 5. 07/20/24 and 07/21/24 nursing staff documented, Dexcom not in place. 6. 08/07/24 and 08/08/24 nursing staff documented, Dexcom unavailable. 7. 08/09/24 nursing staff documented contacted pharmacy regarding Dexcom device, per pharmacy insurance approval still pending. If approved will be delivered 08/09/24. 8. 08/10/24 through 08/13/24 nursing staff documented, Dexcom unavailable. 9. 09/05/24 staff documented Dexcom pending pharmacy. 10. 10/02/24 and 10/03/24 staff documented Dexcom unavailable, ordered from pharmacy. 11. 10/07/24 staff documented Dexcom unavailable, ordered from pharmacy, checked with fingerstick. 12. 10/08/24, 10/11/24 through 10/17/24 staff documented Dexcom not available, assessed with Accu-Check (fingerstick device used to check blood glucose levels). 13. 10/21/24, 10/22/24,10/24/24 and 10/25/24 through 10/27/24 staff documented Dexcom not available, assessed with Accu-Check. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Staff did not document further communication with the pharmacy regarding the Dexcom device being unavailable after 08/09/24. 15. Staff did not document any communication with the physician regarding the physician's order for the Dexcom being unavailable. H. Record review of R # 81's progress notes from July 2024 through October 2024, revealed: 1. 07/28/24 nursing staff documented, Trulicity not available. 2. 08/04/24 nursing staff documented, Trulicity not available. 3. 08/25/24 nursing staff documented, Trulicity not available from pharmacy. 4. 09/01/24 nursing staff documented, Trulicity not administered, unavailable. 5. 09/08/24 nursing staff documented, Trulicity not available. 6. 09/15/24 nursing staff documented, Trulicity not administered, unavailable. 7. 09/22/24 nursing staff documented, Trulicity not available. 8. 09/29/24 nursing staff documented, Trulicity not available. 9. 10/06/24 nursing staff documented, Trulicity not available. 10. 10/13/24 nursing staff documented, Trulicity unavailable. 11. 10/20/24 nursing staff documented, Trulicity unavailable. 11. 10/27/24 nursing staff documented, Trulicity not administered, unavailable. I. On 11/06/24 at 2:08 PM, during an interview with the DON, she stated the following: 1. Staff did not document any attempts to notify the physician regarding R #81's Dexcom being unavailable for several months or that R #81 missed several doses of Trulicity. 2. Her expectation is that staff would contact the physician to notify them that R #81's physician's orders were not followed due to the Dexcom and Trulicity not being available.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47510 Based on record review and interview, the facility failed to provide quality of care for 1 (R #36) of 1 (R #36) resident reviewed for diabetes (chronic condition that happens from persistently high blood sugar levels) when staff did not check blood glucose levels (the process of checking your blood sugar level to ensure they are within a healthy range) and administer diabetic medications. This deficient practice could likely result in R #36 having a higher risk of developing long-term health problems and a higher risk of diabetic ketoacidosis (DKA; a serious complication of diabetes that can be life-threatening. Occurs when blood sugar is very high, and ketones [acids your body makes when it's using fat instead of sugar for energy] build up in the body, causing symptoms of increased thirst, frequent urination, weakness and fatigue). The findings are: A. Record review of R #36's medical record dated 01/18/24, revealed R #36 was referred to hospice. B. Record review of R #36's medical record revealed the record did not contain any documentation R #6 was admitted to hospice. C. Record review of the R #36's Hospice Benefit Revocation form dated 01/30/24 revealed R #36 was admitted to hospice on 01/23/24. R #36 revoked hospice services on 01/30/24 and was discharged from hospice. D. Record review of R #36's physician's orders revealed the following: 1. A prescription for Humalog (a type of insulin used to treat diabetes by controlling blood sugar levels) 100 unit/ml to be injected per sliding scale start date 12/10/23 and discontinue date 01/23/24. 2. A prescription for Metformin (used to help lower blood sugar levels in people with type 2 diabetes) tablet 1000 mg start date 12/10/23 and discontinue date 01/23/24. 3. A prescription for Humalog 100 unit/ml to be injected per sliding scale reorder start date 09/28/24. E. Record review of R #36's progress note dated 09/27/24, revealed the following: 1. Change in condition completed for R #36 due to abnormal vital signs (measurements that fall outside of the normal range for a person's body). LPN # 8 documented that he obtained a blood glucose level (BGL) on R #36 due to history of diabetes. 2. R #36's BGL (Blood glucose level) was 480 (blood glucose level that requires immediate medical attention). LPN #8 contacted physician. 3. R #36's physician recommended one dose of 10 units of Lispro (fast-acting type of insulin). 4. R #36's physician to decide treatment as it is unusual that R #36 is no longer being treated or evaluated for diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #36's medical record, no date, revealed R #36's blood glucose levels were not checked from 01/23/24 to 09/27/24. G. On 11/01/24 at 2:35 PM, during an interview, MDS Coordinator (MDS) #1 said that when R #36 was admitted to hospice on 01/23/24, her insulin was discontinued at that time. MDS #1 said that R #36 was on hospice for seven days, and that R #36's daughter revoked hospice on 01/30/24. MDS #1 confirmed R #36 should have been put back on her insulin when she came off of hospice. H. On 11/05/24 at 1:17 PM, during an interview, the DON said she does not know why R #36 longer had a diagnosis of diabetes. The DON confirmed that R #36 was on hospice for seven days and at that time her insulin was discontinued. The DON confirmed that R #36 did not get BGL checked or insulin from 01/23/24 to 09/27/24. The DON said she did not know why R #36 was not reevaluated after hospice was revoked.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on interview, and record review, the facility failed to keep residents free from accidents for 2 (R #46 and R #64) of 2 (R #46 and R#64) residents reviewed for smoking, when staff failed to complete smoking evaluations to determine resident safety while smoking. This deficient practice could likely result in residents being at risk of serious harm or injury. The findings are: R #46 A. Record review of R #46's admission documents, no date, revealed R #46 was admitted to the facility on [DATE]. B. Record review of the facility's list of residents that smoke, no date, revealed R #46 was a smoker. C. On 10/29/24 at 1:00 PM, during an interview with R #46, he revealed the following: 1. He goes outside to smoke twice a day. 2. He smokes without supervision. D. Record review of R #46's smoking evaluation, dated 10/07/24, revealed the following: 1. R #46 may not smoke independently pending review by the interdisciplinary team. 2. R #46 stated he will not be smoking during stay. E. On 11/04/24 at 8:51 AM, during an interview with the Activities Director, the following was confirmed: 1. R #46 was allowed to smoke without supervision (she was unable to determine when R #46 decided he was going to smoke at the facility). 2. R #46's smoking evaluation indicated that he was not allowed to smoke independently. 3. R #46's smoking evaluation indicated that he would not be smoking at the facility. 4. R #46 had initially stated that he would not be smoking, but a few days later, his family brought him smoking supplies. 5. Nursing staff completes smoking evaluations on all residents who smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Nursing staff complete smoking evaluations quarterly or if something occurs that would indicate that the resident's ability to smoke safely has changed. 7. Nursing staff did not complete another smoking evaluation on R #46 after he decided he wanted to smoke. F. On 11/05/24 at 1:17 PM, during an interview with MDS Coordinator #2, the following was revealed: 1. R #46 was not reevaluated for smoking safety after he decided he wanted to smoke. 2. Nursing staff should have completed another smoking evaluation on R #46 after he decided that he was going to smoke. G. On 11/06/24 at 1:06 PM, during an interview with the DON, she confirmed that nursing staff would be expected to complete a smoking risk evaluation on a resident who decides to smoke while they are a resident at the facility. R #64 H. Record review of R #64's admission documents, no date, revealed R #6 was admitted to the facility on [DATE]. I. Record review of the facility's list of residents that smoke, no date, revealed R #64 was a smoker. J. On 10/28/24 at 2:57 PM, during an interview with R #64, the following was revealed: 1. He had an incident where he was smoking a cigarette in his room at night. 2. The facility took his smoking supplies away. 3. He used to be able to smoke whenever he wanted. 4. The facility had set specific times for smoking. 5. The facility had started locking up smoking equipment and only lets them have them at the set times. K. Record review of R #64's progress note, dated 09/07/24, revealed the following: 1. R #64 was found smoking in his room while using oxygen on 09/06/24. 2. Staff found two lighters, five vape pens, and three empty packs of cigarettes. L. Record review of R #64's smoking evaluation, dated 07/21/24, revealed the following: 1. R #64 was safe to smoke independently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R #64 was able to keep cigarette and lighting materials. 3. Facility staff did not complete another smoking evaluation after R #64 was found smoking in his room on 09/06/24. M. Record review of R #64's care plan, dated 01/26/24, revealed the following: 1. R #64 was able to keep his cigarettes and lighter in his room. 2. R #64 was able to smoke independently. N. On 11/05/24 at 1:21 PM, during an interview with LPN #16, the following was confirmed: 1. R #64 was caught smoking in his room on 09/06/24. 2. Staff did not complete another smoking evaluation after R #64's incident on 09/06/24. 3. Staff should have completed another smoking evaluation after R #64's incident on 09/06/24. O. On 11/06/24 at 1:14 PM, during an interview with the DON, the following was confirmed: 1. R #64 was caught smoking in his room on 09/06/24. 2. R #64 used oxygen. 3. She considered R #64 smoking in his room a behavior. 4. R #64 was reeducated on smoking safety and had not had any other incidents since 09/06/24. 5. Staff would not be expected to reevaluate R #64's smoking safety after the behavior of smoking in his room (contradicting LPN #16's statement in finding N).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on interviews, observation, and record review, the facility failed to ensure a resident who entered the facility with an indwelling Foley catheter [a tube inserted through the urethra (the tube through which urine leaves the body) and into the bladder to drain urine] received appropriate treatment for 2 (R #77 and R #85) of 2 (R #77 and R #85) residents reviewed for urinary catheter care, when they failed to: 1. Assess R #77 for urinary retention (a condition that occurs when a person is unable to empty their bladder, either partially or completely) after the removal of her foley catheter. 2. Remove R #85's Foley catheter after the completion of bladder training (a behavioral technique that can help people regain bladder control.) These deficient practices could likely result in residents being susceptible (likely to be influenced) to infection due to the use of a Foley catheter or urinary retention after the removal of a Foley catheter. The findings are: R #77 A. On 10/28/24 at 3:17 PM, during an interview, R #77's family member stated the following: 1. LPN #17 removed R #77's Foley catheter on 10/27/24. 2. Staff did not check on R #77 for 11 hours after the removal of the Foley catheter. 3. R #77 felt like her bladder was full, and she experienced pain. 4. R #77 was sent to the hospital on 10/27/24. 5. The hospital staff placed a catheter into R #77's bladder on 10/27/24, and R #77 had 800 milliliters (ml; unit of measure) of urine output. 6. R #77 returned to the facility on [DATE] and did not have a Foley catheter when she returned. 7. R #77 was able to urinate a little after she returned from the hospital. B. Record review of R #77's physician's order, dated 10/22/24, revealed an order for bladder training every four hours and foley catheter removal by 10/23/24. C. Record review of R #77's Treatment Administration Record (TAR), dated October 2024, revealed staff documented the following: 1. On 10/22/24 at 4:00 PM, staff completed the clamp and release of R #77's foley catheter for bladder training. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 10/22/24 at 8:00 PM, staff completed the clamp and release of R #77's foley catheter for bladder training. 3. On 10/23/24 12:00 AM, staff completed the clamp and release of R #77's foley catheter for bladder training. 4. On 10/23/24 4:00 AM, staff completed the clamp and release of R #77's foley catheter for bladder training. 5. On 10/23/24 at 8:00 AM, staff completed the clamp and release of R #77's foley catheter for bladder training. 6. On 10/23/24 12:00 PM, staff completed the clamp and release of R #77's foley catheter for bladder training. D. Record review of R #77's nursing progress note, dated 10/27/24, revealed the following: 1. Staff documented at 9:48 AM: a. R #77 tolerated bladder training without complaint of pain or discomfort (See Finding C, Resident completed bladder training on 10/23/24). b. Staff removed R #77's foley catheter after she ate breakfast. c. R #77's family reported R #77 had pain to her perineal area (the area between the genitals and the anus.) d. Staff educated R #77 and her family about prolonged Foley use and doctor's orders. e. Staff would monitor R #77 to ensure she urinated. 2. Staff documented at 4:18 PM: a. R #77 had one wet brief since the Foley catheter removal. Staff did not document the time of the wet brief or the amount of urine that was voided. b. Staff educated R #77 that she needed to get out of bed and empty her bladder by bearing down (push with steady pressure.) E. Record review of progress note, dated 10/28/24, revealed the following: 1. R #77 reported pain to lower abdomen and perineal area. 2. R #77's family told staff that R #77 had not urinated since 9 AM. 3. R #77's family member told staff she wanted R #77 to go to the hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. He stated staff should assess residents for urinary retention hourly after the removal of a Foley catheter. 7. He stated that on 10/27/24, he went in to assess R #77, and her family member was changing her (he was unsure of the time). 8. He checked R #77's brief, and it was heavy with urine. 9. When R #77's family was present, they did not allow staff to assist with R #77's care unless they requested help. I. On 11/05/24 at 10:39 AM, during an interview with ADON #2, he stated staff should assess a resident at least every four hours for 24 hours after staff removed a Foley catheter to ensure the resident did not retain urine. J. On 11/05/24 at 10:42 AM, during an interview with the DON, she stated the following: 1. R #77's Foley catheter was removed on 10/27/24. 2. She was unable to determine if staff assessed R #77 for urinary retention between the time staff removed the resident's Foley catheter in the morning and the time staff wrote the resident's progress note on 10/27/24 at 4:16 PM. 3. R #77 was transferred to the hospital on the evening of 10/27/24. 4. R #77 returned to the facility with diagnoses of urinary retention, constipation, and urinary tract infection. K. Record review of the facility's Indwelling (Foley) Catheter Removal policy, revised August 2022, revealed the following: 1. Steps in the Procedure: a. Assist the resident into the supine position (a position where a person lies on their back with their face and torso facing up.) b. Place a waterproof pad under the resident. 2. Document the following in the resident's medical record: a. The date and time the procedure was performed. b. The name and title of the individual(s) who performed the procedure. c. All assessment data (e.g., urine amount, color, clarity, etc.) obtained during the procedure. d. The time and amount of first void after catheter removal. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. How the resident tolerated the procedure. R #85 L. On 10/28/24 at 1:12 PM, during an observation and interview with R #85, the following was revealed: 1. A Foley catheter collection bag (also called a drainage bag; a device connected to the catheter tubing and collects urine) hung on R #85's bed frame. 2. R #85 stated she had the Foley catheter for about three months. 3. R #85 stated she asked the doctor if they could remove her Foley catheter. 4. The doctor told R #85 they could remove her Foley catheter when she was more active. M. Record review of R #85's admission record, no date, revealed the following: 1. R #85 was admitted to the facility on [DATE]. 2. R #85 had the following diagnoses: a. Urinary tract infection (a bacterial infection that affects the urinary tract, which includes the bladder, uretha, and kidneys). b. Bladder disorder, unspecified (a urinary bladder disease includes urinary bladder inflammation such as cystitis, bladder rupture, and bladder obstruction.) N. Record review of R #85's physician's order, dated 09/03/24, revealed an order to clamp R #85's Foley catheter for 15 minutes every 4 hours for a total of 24 hours for bladder training then remove the foley catheter. O. Record review of R #85's Treatment Administration Record (TAR), dated September 2024, revealed staff documented the following: 1. On 09/03/24 at 4:00 PM, they completed the clamp and release of R #85's foley catheter for bladder training. 2. On 09/03/24 at 8:00 PM, they completed the clamp and release of R #85's foley catheter for bladder training. 3. On 09/04/24 at 12:00 AM, they completed the clamp and release of R #85's foley catheter for bladder training. 4. On 09/04/24 at 4:00 AM, they completed the clamp and release of R #85's foley catheter for bladder training. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. On 09/04/24 at 8:00 AM, they completed the clamp and release of R #85's foley catheter for bladder training. 6. On 09/04/24 at 12:00 PM, they completed the clamp and release of R #85's foley catheter for bladder training. P. Record review of R #85's progress notes, dated 08/27/24 through 11/05/24, revealed staff did not document R #85's Foley catheter was removed, any information pertaining to the procedure, or assessment of R #85 for urinary retention after the removal of the Foley catheter. Q. Record review of R #85's medical record revealed staff did not document any orders for the placement of a foley catheter (after the order for removal on 09/03/24). R. On 11/05/24 at 10:00 AM, during an interview, LPN #17 stated the following: 1. He removed R #85's Foley catheter after bladder training was completed on 09/04/24. 2. He returned to work on a different day (he was unsure what day) and R #77 had a foley catheter in place. 3. He was unsure who re-inserted R #77's foley catheter. 4. He confirmed that he did not document the removal of R #85's foley catheter, how she tolerated the procedure, or that he assessed her for urinary retention after the removal of the catheter. 5. He stated R #85 did not have an order to have a Foley catheter. S. On 11/05/24 at 10:06 AM, during an interview with R #85, she stated staff did not remove her foley catheter in September 2024 (Contradicting LPN #17's statement in finding R). T. On 11/05/24 at 10:25 AM, during a joint interview, the DON and ADON #2 the following was confirmed: 1. A resident should not have a foley catheter without a physician's order. 2. R #85 had an order for bladder training and foley catheter removal on 09/03/24. 3. R #85 did not have an order to have a foley catheter after 09/04/24. 4. R #85's medical record did not have documentation that her Foley catheter was removed after the completion of bladder training on 09/04/24. 5. ADON #2 stated that he assessed R #85 on 09/05/24 and that she had a foley catheter in place. 6. The expectation was for staff to follow orders for bladder training and removal of a foley catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The expectation was for staff to document the removal of a foley catheter and any assessment information. 8. She was unable to determine if staff removed R #85's foley catheter on 09/04/24.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 47510 Based on interview and record review, the facility failed to ensure the licensed nurses (RN's and LPN's) and CNA's are able to demonstrate competency in skills and techniques necessary to care for residents' needs for 5 (CNA #8, CNA #9, LPN #8, LPN #9, and LPN #10) of 5 (CNA #8, CNA #9, LPN #8, LPN #9, and LPN #10) reviewed for competent nursing staff. This could affect all 94 residents in the facility (residents were identified by Resident Matrix provided by the DON on 10/28/24). This deficient practice could likely result in nurses and CNA's working with residents without adequate knowledge to do so; likely resulting in injury or inappropriate care being provided to the residents. The findings are: A. Record review of LPN #8's personnel files revealed the following: 1. LPN #8 was hired on 10/26/23. 2. Competency evaluation was not completed (the measurement of an individual's knowledge and skills as related to safe, competent performance) for LPN #8. B. Record review of LPN #9's personnel files revealed the following: 1. LPN #9 was hired on 08/10/23. 2. Competency evaluation was not completed for LPN #9. C. Record review of LPN #10's personnel files revealed the following: 1. LPN #10 was hired on 07/18/24. 2. Competency evaluation was not completed for LPN #10. D. Record review of CNA #8's personnel files revealed the following: 1. CNA #8 was hired on 09/20/23. 2. Competency evaluation was not completed for CNA #8. E. Record review of CNA #10's personnel files revealed the following: 1. CNA #10 was hired on 01/16/18. 2. Competency evaluation was not completed for CNA #10. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. On 11/06/24 at 11:24 AM, during an interview, the DON confirmed LPN #8, LPN #9, LPN #10, CNA #8, and CNA #9 did not have a competency evaluation. The DON said that competencies should be done upon hire, before working the floor, and annually after that. The DON said that all nursing staff and CNA's should complete competency evaluations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observation, record review and interview, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met for 1 (R #251) of 5 (R #52, R #59, R #60, R #81 and R #251) residents reviewed for medications when they failed to provide routine medication for a resident. This deficient practice could likely lead to unresolved or worsening of medical issues. The findings are: A. Record review of R #251's admission record (no date) revealed R #251 was admitted [DATE]. B. On 11/04/24 at 8:46 AM, during observation of medication pass by LPN #1, revealed the following: 1. LPN #1 stated he would not administer medications to R #251 because the medications were not available. 2. LPN #1 stated R #251's medications were on order from the pharmacy, since she was a new admission (admission within the last 30 days) she gets partial fills (less than 30-day supply) from the pharmacy. C. Record review of R #251's Physician's orders revealed the following: 1. Order date 10/23/24; iron (medication used to treat or prevent low levels of iron such as those caused by anemia [low number of red blood cells that can affect your oxygen supply and cause various symptoms]) 27 tablet, give 240 mg by mouth one time a day for anemia. 2. Order date 10/23/24; pantoprazole (medication that reduces the amount of acid produced in the stomach) tablet, give 40 mg by mouth two times a day for gastroesophageal reflux disease (GERD; condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus). 3. Order date 10/23/24; atorvastatin (medication that reduces the amount of acid produced in the stomach) tablet, give 10 mg by mouth one time a day for high-density lipoprotein cholesterol (HDL; cholesterol in the blood). D. Record review of R #251's medication administration record (MAR; form used to documentation medication administration) for October 2024 revealed the following: 1. 10/23/24 pantoprazole was marked as not administered, see progress notes. 2. 10/24/24 iron was marked as not administered, see progress notes. E. Record review of R #251's MAR for November 2024 revealed the following: 1. 11/01/24 through 11/05/24 pantoprazole was marked as not administered, see progress notes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. 11/04/24 atorvastatin was marked as not administered, see progress notes. 2. 11/06/24 iron was marked as not administered, see progress notes. F. On 11/06/24 at 1:00 PM, during an interview, with CMA #1 the following was revealed: 1. R #251's pantoprazole and iron were still on order from the pharmacy. 2. The pharmacy often delivers partial fills, sometimes it will be a 3-day supply or a 7-day supply. G. Record review of R #251's progress notes for October and November 2024 revealed the following: 1. 10/23/24 staff did not document the reason R #251 did not receive her pantoprazole. 2. 10/24/24 and 11/06/24 staff documented iron was on order. 3. 11/01/24, 11/02/24, 11/04/24, 11/05/24 and 11/06/24 staff documented pantoprazole was on order. 4. 11/04/24 staff did not document the reason R #251 did not receive her atorvastatin. H. On 11/06/24 at 2:08 PM, during an interview with the DON, she stated the following: 1. R #251 was a new admission to the facility and had missed doses of her medications. 2. The facility has had problems with receiving medications from the facility contract pharmacy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers) unless the medication was medically necessary for 3 (R #5, R #26 and R #48) of 5 (R #5, R #26, R #31, R #33 and R #48) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications without a medical reason or when no longer necessary, placing these residents at a higher risk of adverse side effects (unwanted, harmful, or abnormal result) when the facility failed to: 1. Carry out a gradual dose reduction (GDR; stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) and failed to document clinical rationale to continue psychotropic medications for R #5 and R #48. 2. Ensure that antipsychotic for R # 26 was prescribed to treat a specific psychiatric diagnosis (mental illness, symptoms or condition that greatly disturbs your thinking, moods, and/or behavior). R #5 A. Record review of R #5's admission record, no date, revealed the following: 1. R #5 was admitted to the facility on [DATE]. 2. R #5 diagnoses include major depressive disorder, single episode, severe without psychotic features (single occurrence of feelings of low mood and loss of interest in activities without having delusions or hallucinations). B. Record review of R #5's pharmacy note to attending physician/prescriber dated 06/14/24 revealed: 1. R #5 has been taking sertraline (antidepressant medication often used to treat depression) 25 mg at bedtime for depression since 12/02/21, please evaluate the current dose and consider dose reduction. 2. The form was marked agree and signed but not dated by the medical director. 3. The form was marked see physician progress notes for clinical rationale. C. Record review of R #5's physician's orders revealed the following: 1. Order start date 12/02/21 and discontinued 07/12/24; sertraline 25 mg give 1 tablet by mouth at bedtime for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Order start date 07/12/24 and discontinued 10/17/24; sertraline 25 mg give 12.5 mg by mouth at bedtime for depression. 3. Order start date 10/17/24; sertraline 25 mg give 1 tablet by mouth at bedtime for depression. D. Record review of R #5's progress notes from 06/01/24 through 10/29/24 revealed the following: 1. Nursing staff did not document any incidents of sadness, crying, depression or self-isolation. 2. Activities staff documented: a. 06/15/24 R #5 gave a smile and a thumbs up when activity staff asked if he would like to practice b. 06/22/24 R #5 gave a thumbs up when I asked him if he would like his hair combed while he was listening to music. He laughed and giggled out loud as I was talking to him. c. 07/13/24 R #5 give (sic) a thumbs up when asked if he would like to participate in exercising with the ball and passing it. He also smiled and laughed out loud during the ball pass. d. 07/20/24 R #5 gave a smile and a thumbs up when staff asked if he would like his hair combed and to listen to music. Resident laughed out loud while stock (sic) combed his hair. e. 08/03/24 R #5 was in good mood today During the visit. He gave a thumbs up laughed out loud and smiled f. 08/23/24 R # 5 was in a pleasant mood. He engaged in conversation and kept eye contact. g. 09/07/24 offered the resident the choice to listen to several different stations and he chose the station he wanted by nodding yes, smiling and giving a thumbs up. h. 09/26/24 R #5 smiles and gave a thumbs up i. 10/05/24 R #5 smiled and used a thumb up to make his choices. j. 10/11/24 R #5 responded well to visit. He gave a thumbs up for the choices of listening to music and participating in ball toss. He kept eye gazes here and there and smiled as well as laugh out loud k. 10/12/23 R #5 was given the option to play ball pass with a football or basketball. He chose the football by grabbing it. He smiled and laughed. l. 10/23/24 R #5 continues to participate actively in small and large group activities (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. 10/26/24 R #5 responded well to visit. He communicated with me by giving a thumbs up and smiling. 3. Social services staff documented: a. 07/22/24 during the evaluation, (name of R #5), appeared to be very happy, smiling at every question asked. The staff also reported observing no symptoms of depression. A PHQ-9 evaluation (an easy-to-use patient questionnaire for screening, diagnosing, monitoring and measuring the severity of depression; 0-4 no depression) was conducted, which resulted in a score of zero. b. 10/20/24 during the evaluation, (name of R #5) appeared to be very happy, smiling at every question asked. The staff also reported observing no symptoms of depression. A PHQ-9 evaluation was conducted, which resulted in a score of zero. E. On 11/06/24 at 2:24 PM, during an interview with the DON, she confirmed that there was no rationale in R #5's medical record from the physician regarding the need for increase. R #26 F. Record review of R #26's admission documents, no date, revealed the following: 1. R #26 was admitted to the facility on [DATE]. 2. R #26 had a diagnosis of Depression (a mental health condition that can affect anyone, causing a persistent low mood and loss of interest in activities). G. Record review of R #26's physician's orders, multiple dates, revealed the following: 1. An order dated 08/21/24 and discontinued 10/21/24, for Olanzapine (an antipsychotic medication used to treat mental disorders, including schizophrenia and bipolar disorder) 2.5 milligrams (mg, unit of measure), give one tablet at bed time for Major Depressive Disorder (MDD, a serious mental health condition that involves a persistent low mood and loss of interest in activities). 2. An order, dated 10/22/24, for Olanzapine 2.5 mg, give 2 tablets one time a day for MDD related to depression. H. Record review of R #26's Medical Record revealed the resident did not have a psychiatric diagnosis to indicate the need for an antipsychotic. I. On 11/05/24 at 1:25 PM, during an interview with MDS Coordinator #2, she confirmed the following: 1. R #26's order for Olanzapine is for the diagnosis of MDD for Depression. 2. Olanzapine is an antipsychotic medication. 3. R #26 did not have an appropriate diagnosis for the use of an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 11/06/24 at 1:21 PM, during an interview with the DON, she confirmed R #26 did not have a psychiatric diagnosis for the antipsychotic medication. The DON stated the physician ordered the antipsychotic medication for R #26's depression. R #48 K. Record review of R #48's admission record, no date, revealed the following: 1. R #48 was admitted to the facility on [DATE]. 2. R #48 diagnoses include schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). L. Record review of R #48's pharmacy note to attending physician/prescriber dated 06/14/24 revealed: 1. R #48 has been taking duloxetine (antidepressant medication used to treat depression and anxiety) 60mg once a day for depression since 12/22/23, please evaluate the current dose and consider dose reduction. 2. The form was marked resident with good response, maintain current dose. 3. The form was marked and signed but not dated. M. Record review of R #48's physician's orders revealed the following: 1. Order date 12/22/23; duloxetine give 60 mg by mouth once a day for depression. 2. Order date 03/14/24; referral to (name of local behavioral health agency) related to diagnosis of schizophrenia. N. Record review of R #48's medical record revealed: 1. local behavioral health No service form dated 06/04/24: insurance is stating that patient is not meet criteria for ongoing mental health services at this time. O. Record review of R #48's progress notes from 06/01/24 through 10/30/24 revealed the following: 1. Nursing staff did not document any incidents of sadness, crying, or depression. 2. Activities staff documented: a. 07/20/24 R #48 spoke about the different types of food he enjoyed as well as the different types of TV shows and movies he liked. He smiled a lot and laughed out loud . Resident responded well to visit and was very pleasant b. 08/03/24 R #48 was in a good mood and smiled while he talked to me for this visit. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. 08/17/24 R #48 was in a good mood this afternoon. He smiled and laughed out loud during visit. Resident spoke about how much he enjoyed playing baseball. He spoke about his time on a team. c. 09/26/24 R #48 responded well to visit. He engaged in conversation and smiled throughout the visit. 3. Social services staff documented: a. 06/19/24 R #48 has reported an absence of depressive symptoms, is feeling significantly improved, and the staff have observed no negative behaviors this quarter. A PHQ-9 evaluation was administered, yielding a score of zero. b. 09/18/24 R #48 has reported feelings of depression, disturbed sleep, and loss of energy, and the staff have observed no negative behaviors this quarter. A PHQ-9 evaluation was administered, yielding a score of 7- mild depression. P. On 11/06/24 at 2:30 PM, during an interview with the DON, she confirmed, that there was no rationale from the physician in R #48's medical record regarding the GDR recommendation for R #48. 49313

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on interview and record review the facility failed to ensure residents obtained dental services for 4 (R #41, R #50, R #81, and R #84) of 4 (R #41, R #50, R #81, and R #84) residents sampled for dental services, when: 1. Receive routine dental care to include an annual inspection of the mouth for signs of disease, dental cleaning, fillings, or minor partial or full denture adjustments for R #41 and R #50. 2. Schedule required dental follow-up for R #50 and R # 81. 3. Emergency dental services for R#84. These deficient practices are likely to cause the resident unnecessary pain, embarrassment over the condition and/or appearance of teeth, and potential dental or oral complications. The findings are: R #41 A. On 10/29/24 at 11:01 AM, during an interview with R #41's power of attorney, she stated R #41 had been at the facility for over one year and she would like R #41 to go to the dentist for her regular appointments and to have her teeth cleaned. B. Record review of R #41's admission record revealed R #41 was admitted to the facility on [DATE]. C. Record review of R #41's medical record revealed, R #41 has not had any dental visits. D. On 11/06/24 at 2:50 PM, during an interview, the health information specialist (HIS; facility staff that obtains, organizes and manages medical records) confirmed R # 41 had not been to the dentist after her admission to the facility. R #50 E. On 10/29/24 at 2:37 PM, during an interview with R #50, she stated she had not been to the dentist, but would like to go for her annual checkup. F. Record review of R #50's admission record revealed R #50 was admitted to the facility on [DATE]. G. Record review of R #50's medical record revealed R #50 was seen by a local dentist on 08/30/23 for her regular checkup. H. Record review of R #50's progress notes revealed the following: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 08/08/24, nursing staff documented, new orders received for R #50 to start metronidazole (antibiotic used to treat gum infections and dental abscesses) 500 mg by mouth, every eight hours for five days. Cefdinir (antibiotic used to treat a wide variety of infections) 300 mg by mouth, twice daily for five days, and chlorhexidine rinse (antiseptic mouthwash), swish and spit twice daily for dental infection. Dental referral received from nurse practitioner and delivered to scheduler/transportation for scheduling. 2. On 08/23/24 social services staff documented, ancillary needs (address dental, visual, auditory and podiatry needs): R #50 requested dental. I. On 11/06/24 at 2:50 PM, during an interview, HIS confirmed R #50 had not been to the dentist after her last visit on 08/30/23. R #81 J. On 10/29/24 at 9:41 AM, during an interview with R #81, she stated she had been to the dentist approximately two months ago and was waiting for follow up appointment to have a tooth extracted (removal of tooth). K. Record review of R #81's medical record revealed the following: 1. R #81 was seen by the dentist on 08/07/24. 2. Dental visit note dated 08/07/24 revealed R #81 was referred to an oral surgeon due to a fractured tooth (cracked tooth) with abscess (pocket of pus in tooth caused by infection). L. On 11/06/24 at 2:50 PM, during an interview, HIS confirmed R #81 had not been seen by an oral surgeon for her extraction. R #84 M. On 10/28/24 at 1:50 PM, during an interview with R #84, the following was revealed: 1. He told staff that he had broken teeth on the top and bottom of his right side of his mouth. 2. Staff scheduled an appointment for him, but it was on the day his parents visit him. 3. Staff have not told him if his appointment was rescheduled. N. Record review of R #84's admission record, no date, revealed the following: 1. R #84 was admitted to the facility on [DATE]. 2. R #84 had the following diagnoses: a. Multiple Sclerosis (a chronic disease that affects the central nervous system, including the brain and spinal cord) (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Need for Assistance with Personal Care c. Muscle Weakness O. Record review of R #84's physician progress note, dated 08/20/24, revealed the following: 1. R #84 reported a broken lower molar to the provider. 2. The provider would refer R #84 to the dentist. P. Record review of R #84's nursing progress notes, multiple dates, revealed R #84 received ordered as needed Acetaminophen (medication that can treat minor aches and pains) for tooth pain on the following dates: -08/23/24, -08/25/24, -08/29/24, -08/30/24, -09/02/24, -09/06/24, -09/10/24, -09/13/24, -09/15/24, -09/22/24, -09/23/24, -09/24/24, -09/26/24, -10/05/24, -10/06/24, -10/11/24, -10/16/24, (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/17/24, -10/19/24, -10/20/24, -10/23/24, -10/25/24, -10/27/24, -10/28/24, -10/29/24, -10/30/24, -11/03/24. Q. On 11/04/24 at 10:05 AM, during an interview with the receptionist, the following was revealed: 1. R #84 had an appointment scheduled with the dentist on 10/23/24 but R #84 canceled it. 2. R #84 had an appointment rescheduled with the dentist on 11/11/24. 3. The scheduler was not notified that R #84 needed a dental appointment until 09/19/24. R. On 11/06/24 at 1:08 PM, during an interview with the DON, the following was confirmed: 1. If a resident reported pain from a broken tooth, staff would be expected to follow the process to get the resident seen by a dentist. 2. The provider documented that she would refer R #84 to the dentist on 08/20/24 due to pain from a broken tooth. 3. She was unable to determine if the provider referred R #84 to the dentist or notified anyone to have a dental appointment scheduled. 49313

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	11/06/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49313 Based on observation and interview, the facility failed to store and serve food under sanitary conditions by professional standards of food service safety. This failure could potentially affect all 40 residents on the north unit (residents were identified by the Resident Matrix provided by the Administrator on 10/28/24). When they failed to ensure staff maintain refrigerator temperatures in the nutrition refrigerators. If the facility fails to adhere to safe food storage, residents could likely be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On 11/04/24 at 11:31 AM, during an observation of the nourishment room refrigerator by nurses station on the north unit, the following was revealed: 1. The refrigerator thermometer read 48 degrees Fahrenheit. 2. There was condensation on the back wall inside the refrigerator. B. Record review of the refrigerator temperature log for the nourishment room by the nurses station on the north unit revealed the following: 1. The log stated refrigerator temperature should be between 36-46 degrees Fahrenheit [foods must be maintained at or below 41 degrees Farenheit]. 2. The refrigerator temperatures log was for October 2024. 3. The log did not contain any recording of temperatures for November 2024. C. On 11/04/24 at 11:31 AM, during an interview with ADON #1, she confirmed the following: 1. The nourishment room refrigerator by nurses station on the north temperature was 48 degrees Fahrenheit. 2. The appropriate temperature should be between 36-46 degrees Fahrenheit [foods must be maintained at or below 41 degrees Fahrenheit]. 3. Night shift nurses are expected to check the refrigerator temperature every evening. 4. Staff did not check the temperature for the refrigerator after 10/31/24. 5. There was condensation on the back wall inside of the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 11/06/24 at 1:27 PM, during an interview with the DON, she confirmed the staff are expected to write down the temperatures daily and fix the refrigerator if the temperature is out of range.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on observation and interview, the facility failed to ensure call lights worked at all times as intended for Rooms 133 to 152 on the South Unit reviewed for call system functioning. This deficient practice could likely result in residents being unable to notify staff when they are in need of assistance. The findings are: A. On 10/29/24 at 12:46 PM, during an interview, a resident stated sometimes her call light does not work. The resident said it happens often and she had told staff, but it still happens. B. On 10/29/24 at 2:21 PM, during an interview, a resident stated her call light does not work half the time. The resident said that she had told staff. C. On 10/28/24 at 1:28 PM, during an interview, a resident stated her call light does not work sometimes. She said that if a resident's call light gets unplugged, then none of the call lights on the unit will work. She said that it seems to happen mostly at night. The resident stated she is unable to call for help because she can not really yell. She said she had told the maintenance director. D. On 10/31/24 at 3:43 PM, during an observation, the call light in room [ROOM NUMBER] A was unplugged from the wall. The call light in 137 A did not light up outside the room when it was unplugged. When the call light in 137 A was unplugged, the call light in rooms 133 through 145 did not work. E. On 10/31/24 at 3:43 PM, during an interview, the Maintenance Director confirmed the call lights for rooms 133 to 145 did not light up when the call light in room [ROOM NUMBER] A was unplugged. F. On 11/04/24 at 1:31 PM, during an interview, a resident stated her call light does not work at all sometimes. She said that if another resident's call light gets pulled from the plug than the other call light on the unit will not work. The resident aid that she had told staff and that they have given her a cowbell to use when the call light does not work. G. On 11/04/24 at 2:50 PM, during an observation, the call light in room [ROOM NUMBER] was unplugged from the wall. When the light was unplugged, the light did not light up outside room [ROOM NUMBER]. When the call light in room [ROOM NUMBER] was unplugged, the call lights in rooms 146 through 152 on the South Unit did not work. H. On 11/04/24 at 2:50 PM, during an interview, ADON #1 confirmed that when the call light in room [ROOM NUMBER] was unplugged, the call lights in rooms 146 through 152 did not work.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 47510 Based on record review and interview, the facility failed to ensure the nursing staff have completed the mandatory Effective Communication training for 5 (LPN #8, LPN #9, LPN #10, LPN #11, and CNA #8) of 5 (LPN #8, LPN #9, LPN #10, LPN #11, and CNA #8) staff randomly sampled for staffing. This deficient practice could likely result in staff being unable to inform residents of their total health status and to provide notice of rights and services. The findings are: A. Record review of LPN #8's Online Training Transcript revealed the Effective Communication training was not completed. B. Record review of LPN #9's Online Training Transcript revealed revealed the Effective Communication training was not completed. C. Record review of LPN #10's Online Training Transcript revealed the Effective Communication training was not completed. D. Record review of LPN #11's Online Training Transcript revealed the Effective Communication training was not completed. E. Record review of CNA #8's Online Training Transcript revealed the Effective Communication training was not completed. F. On 11/06/24 at 11:24 AM, during an interview, the DON confirmed that Effective Communication Training has not been completed.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47510 Based on interview and record review, the facility failed include performance reviews as part of their 12 hours of annual training for 1 (CNA #9) of 2 (CNA #8 and CNA #9) CNAs sampled for 12 hours of annual training. This deficient practice could likely result in staff being under trained and providing inadequate care. The findings are: A. Record review of CNA #9's personnel records revealed CNA # 9 date of hire was 01/16/18. B. Record review of CNA #9's training records revealed the record did not any contain performance evaluations. C. On 11/06/24 at 11:24 pm, the DON confirmed CNA #9 had been working at the facility for more than a year. The DON confirmed that the performance evaluation for CNA #9 was not completed and the 12 hours of annual training was not done based on the performance evaluation.