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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325067	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Cruces Village Nursing & Rehabilitation LLC	3025 Terrace Drive Las Cruces, NM 88011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on interview and record review, the facility failed to keep residents free from involuntary seclusion (separation of a resident from other residents, from her/his room or confinement to her/his room [with or without roommates] against the resident's will, or the will of the resident representative) for 1 (R #1) of 3 (R #1, R #2, and R #5) residents sampled for involuntary seclusion when the staff failed to allow a resident to move freely throughout the unit. This deficient practice is likely to result in residents experiencing anxiety and/or depression related to being isolated from staff and other residents. The findings are: A. Record review of R #1's face sheet revealed the following: 1. Original admitted [DATE]. 2. Diagnoses; Alzheimer's disease (brain condition that causes a decline in memory, thinking, learning and organizing skills over time), insomnia (sleep disorder that can make it hard to fall asleep or stay asleep) and hypertension (high blood pressure). B. Record review of the facility's incident report for R #1, dated 09/03/24 revealed on 09/02/24, R #1's bedroom doorway was blocked by the bed, while R #1 was in the room. C. On 12/13/24 at 1:32 PM, during an interview, RN #1 stated the following: 1. She was the nurse assigned to care for R #1 on 09/02/24. 2. On 09/02/24 the DON informed her that R #1's doorway was blocked by the bed. 3. She went to R #1's room (cannot recall the time) and R #1's doorway was no longer blocked by the bed. D. On 12/16/24 at 1:58 PM, an interview, the administrator stated the following: 1. On 09/02/24 during the day shift, CNA #1 blocked R #1's doorway with the bed while R #1 was in his room because he was wandering around the unit and into other resident's bedrooms. (continued on next page)

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

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

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per the administrator facility staff should not confine residents to their room against their will. 3. The administrator confirmed that R #1 was involuntary secluded by the facility staff on 09/02/24.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41755 Based on observation and interview, the facility failed to maintain proper infection prevention measures when they failed to ensure facility staff follow transmission-based precautions (actions to prevent the spread of infectious agents from individuals who are suspected to be infected, such as gloves, facemasks, and gowns) for residents diagnosed with COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions). Failure to adhere to an infection control program could likely cause the spread of infections and illness to all 67 residents in the facility (residents were identified by the resident matrix provided by the administrator on 12/11/24). The findings are: A. On 12/11/24 at 9:33 AM, during an interview, the front desk staff stated the following: 1. The facility currently has residents diagnosed with COVID-19. 2. All staff and visitors must wear N95 masks (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) while in the facility. B. On 12/11/24 at 9:35 AM, during an observation of the Alzheimer unit RN #2 sat at the nurse's station and did not wear a N95 mask. C. On 12/11/24 at 9:46 AM, during an observation of the East unit and interview with LPN #1 revealed the following: 1. LPN #1 wore a surgical mask, and the mask did not cover her nose. 2. LPN #1 stated she was not informed what kind of mask to wear on the unit. 3. LPN #1 stated she does wear an N95 when entering the room of a resident diagnosed with OVID-19. D. On 12/11/24 at 1:50 PM, during an observation of the East unit the following was revealed: 1. CNA #2 was in the hallway near the nurse's station and wore a surgical mask. 2. The wound care nurse advised CNA #2 that facility staff are required to wear N95 masks on the nursing units. E. On 12/12/24 at 3:08 PM, during an observation of the [NAME] unit LPN #2 sat at the nurse's station and did not wear a mask. F. On 12/16/24 at 12:58 PM, during an interview with the regional nurse consultant (RNC), she stated that all facility staff are required to wear N95 masks, on the nursing units and while providing care in patient care areas (resident rooms, nursing units, kitchen, dining room) when the facility has a resident diagnosed with COVID-19.