STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: Las Cruces Village Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 3025 Terrace Drive 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #16) of 1 (R #16) resident when staff failed to adequately assess the cause and adequately treat R #16's prolonged diarrhea. Failure to adequately assess the cause of diarrhea and provide appropriate treatment could likely lead to worsening of resident's condition. The findings are: A. Record review of R #16's admission record, no date, revealed R #16 was admitted to the facility on [DATE] with the following diagnoses: a. Metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance). b. Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy). c. Unspecified Dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and decision-making, severe enough to interfere with daily life and activities). d. Delirium (an acute state of mental confusion characterized by a rapid onset of altered consciousness, cognitive impairment, and changes in behavior and perception). e. Dysphagia (difficulty swallowing). f. Gastrostomy status (a surgical opening into the stomach for nutritional support) B. Record review of R #16's admission assessment, dated 11/15/24, revealed the following: 1. R #16 speech was unclear. 2. R #16 had a percutaneous endoscopic gastrostomy (PEG, a thin, flexible tube inserted through the abdominal wall and into the stomach) on his upper mid abdomen. 3. R #16 received nutrition through his PEG tube. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R #16 was incontinent (having no or insufficient control over urination or defecation) and had diarrhea. 5. R #16 had a cognitive communication deficit (communication difficulty caused by a cognitive impairment). C. Record review of R #16's activities of daily living (ADL, basic tasks that people do every day, such as eating, dressing, and using the toilet) sheet, dated November 2024, revealed staff documented R #16's bowel movements as follows: a. On the evening shift of 11/16/24, R #16 had a large bowel movement that was loose (also known as diarrhea)/diarrhea. b. On the day shift of 11/17/24, R #16 had a large bowel movement that was loose /diarrhea. c. On the evening shift of 11/17/24, R #16 had a medium bowel movement that was loose /diarrhea. d. On the day shift of 11/19/24, R #16 had a large bowel movement that was loose /diarrhea. e. On the day shift of 11/20/24, R #16 had a large bowel movement that was loose /diarrhea. f. On the evening shift of 11/20/24, R #16 had medium bowel movement that was putty like (can be caused by issues with biliary system, high fat, or dehydration). g. On the day shift of 11/22/24, R #16 had a large bowel movement that was putty like. h. On the day shift of 11/24/24, R #16 had a large bowel movement that was loose /diarrhea. i. On the day shift of 11/26/24, R #16 had a large bowel movement that was loose /diarrhea. j. On the day shift of 11/28/24, R #16 had a small bowel movement that was loose /diarrhea. k. On the day shift of 11/29/24, R #16 had a small bowel movement that was loose /diarrhea. l. On the evening shift of 11/29/24, R #16 had a large bowel movement that was putty like. D. Record review of R #16's nursing progress note, dated 11/17/24, revealed staff documented that R #16 had diarrhea. E. Record review of R #16's nursing progress note, dated 11/19/24, revealed the following: 1. R #16 had diarrhea. 2. The provider was contacted and gave an order for Imodium A-D 4 mg PRN. F. Record review of R #16's nursing progress note, dated 11/20/24, revealed R #16 had diarrhea. G. Record review of R #16's nursing progress note, dated 11/21/24, revealed R #16 had diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #16's ADL sheet, dated December 2024, revealed staff documented R #16's bowel movements as follows: a. On the day shift of 12/01/24, R #16 had a large bowel movement that was loose /diarrhea. b. On the evening shift of 12/01/24, R #16 had a medium bowel movement that was putty like. c. On the day shift of 12/04/24, R #16 had a large bowel movement that was loose /diarrhea. d. On the day shift of 12/05/24, R #16 had a large bowel movement that was loose /diarrhea. e. On the evening shift of 12/05/24, R #16 had a large bowel movement that was loose /diarrhea. f. On the day shift of 12/06/24, R #16 had a medium bowel movement that was putty like. g. On the evening shift of 12/06/24, R #16 had a medium bowel movement that was putty like. h. On the day shift of 12/07/24, R #16 had a bowel movement that was putty like. i. On the evening shift of 12/07/24, R #16 had a small bowel movement that was putty like. j. On the day shift of 12/08/24, R #16 had a small bowel movement that was putty like. k. On the day shift of 12/10/24, R #16 had a large bowel movement that was loose /diarrhea. l. On the evening shift of 12/10/24, R #16 had two (2) large bowel movements that were loose /diarrhea. I. Record review of R #16's physician's orders, multiple dates, revealed the following: 1. Order dated 11/15/24, R #16 to have 135 mL of water through an enteral route by feeding pump every four (4) hours. 2. Order dated 11/15/24, for Linzess (medication used to treat irritable bowel syndrome with constipation and chronic constipation with no known cause; the most common adverse effect includes diarrhea and can be severe) 72 mg once a day through R #16's PEG tube for chronic constipation [R #16 did not have a diagnosis of irritable bowel syndrome or constipation]. 3. Order dated 11/18/24, for R #16 to have nothing by mouth (NPO; an order indicating that a patient should not eat or drink anything). 4. Order dated 11/19/24, for Imodium A-D (anti-diarrhea) 2 mg every 8 hours as needed for diarrhea through R #16's PEG tube. 5. Order dated 12/04/24, for Complete Blood Count (CBC, a routine blood test that measures the number and types of cells in the blood) lab test and Complete Metabolic Panel (CMP, a blood test that measures various substances in the body to assess overall health and metabolism) lab tests. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #16's Medication Administration Record (MAR), dated November 2024, revealed R #16 received Imodium A-D on the following dates: 1. 11/20/24 2. 11/24/24 K. Record review of R #16's MAR, dated December 2024, revealed R #16 did not receive Imodium A-D in the month of December. L. Record review of R #16's Complete Metabolic Panel (CMP, a group of blood tests that measures various substances in the body to asses overall health and metabolism) lab results, dated 12/06/24, revealed the following: 1. Sodium blood level [assessment of the amount of the electrolyte (minerals that help control the amount of fluid and the balance of acids and bases (pH balance) sodium in the body; also helps nerves and muscles work properly] was elevated at 151 millimoles per liter (mmol/L, unit of measure used to measure the concentration of substances in the blood) (normal range was 136-145 mmol/L). 2. Chloride blood level (an important electrolyte that helps maintain fluid balance, blood pressure, and pH levels in the body) was elevated at 120 mmol/L (normal range was 95-108 mmol/L). 3. Blood urea nitrogen (BUN, a common test that checks kidney function) was elevated at 35 milligrams/deciliter (mg/dL, unit of measure the concentration of substances in the blood) (normal range was 6-25 mg/DL). 4. Creatinine (Create, waste product produced by muscle metabolism) was normal at 1.19 mg/dL (normal range was 0.70 - 1.30). 5. BUN/ Create ratio (a blood test that measures the function of the kidneys) was normal at 29 (normal range was 9-30). 6. The laboratory results sheet had a signature indicating the lab results were reviewed (unable to determine who signed the sheet). 7. There was no date indicating when the laboratory results were reviewed. M. Record review of R #16's entire medical record, no date, revealed staff did not document that the provider was notified about R #16's abnormal laboratory results. N. On 02/11/25 at 1:43 PM, during an interview, Medical Doctor (MD) #1 stated the following: 1. Linzess is a medication that is used for the treatment of Irritable bowel syndrome or chronic constipation for which other medications have been ineffective (R #16 did not have a diagnosis of irritable bowel syndrome or chronic constipation in his medical record). 2. Diarrhea is a common side effect of Linzess. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An order for Linzess should include instructions to hold the medication for loose stools or diarrhea (R #16's order did not have instructions to hold for loose stools or diarrhea). 4. Anti-diarrhea medications like Imodium A-D should not be ordered with Linzess because they have opposite effects (Linzess treats constipation and Imodium treats diarrhea). 5. Diarrhea can cause dehydration (when the body loses more fluids than it takes in, resulting in lack of water and electrolytes, can be caused by insufficient fluid intake, excessive sweating, diarrhea, vomiting, fever, and certain medications) if the diarrhea is not stopped and the resident does not receive fluids to replace the fluids that were lost with diarrhea. 6. An elevated sodium level and elevated chloride level combined with a normal BUN/Creat ratio is an indicator of dehydration. O. Record review of R #16's progress note, dated 12/11/24, revealed R #16 fell and was sent to the emergency room . P. Record review of R #16's hospital record, dated 12/11/24, revealed the following: 1. Sodium blood level was elevated at 157 mmol/L (normal level 132-145 mmol/L) 2. Chloride blood level was elevated at 119 mmol/L (normal level 100-112 mmol/L). 3. BUN level was elevated at 25 mg/dL (normal level 9-23 mg/dL). 4. Create level was elevated at 1.42 mg/dL (normal level 0.70-1.30) 5. Diagnoses of severe dehydration and acute kidney injury (a condition where the kidneys suddenly lose their ability to function properly, leading to buildup of waste products in the blood, can be caused by dehydration). Q. On 02/12/25 at 1:34 PM, during an interview with the DON, the following was confirmed: 1. Nursing staff contacted the provider on 11/19/24 to notify them about R #16 having diarrhea, and received an order for Imodium A-D. 2. Nursing staff did not document that the provider was notified about R #16 also having an order for Linzess. 3. Nursing staff should have been familiar with Linzess and the common side effect of diarrhea. 4. Nursing staff should have questioned why R #16 had an order for Linzess and Imodium A-D because they have opposite effects. 5. R #16's medical record did not contain documentation that the nursing staff notified the provider about R #16's diarrhea after 11/19/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Nursing staff should have contacted the provider to request labs to assess R #16's hydration status prior to 12/5/24. 7. R #16 received all of his hydration through his PEG tube (he was unable to drink fluids). 8. R #16's order for water through his PEG tube was the same since admission. 9. Nursing staff should have contacted the provider to request an order for additional fluids for R #16 due to diarrhea.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41755 Based on record reviews and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of 4 (R #1, R #3, R #4, and R #5) of 5 (R #1, R #2, R #3, R #4, and R #5) residents reviewed for staffing when staff failed to: 1. Assist R #1 to the toilet as ordered by the physician. 2. Assist R #3 and R #5 with transfers in and out of bed when requested. 3. Get R #4 up and ready to eat meals in the dining room. These deficient practices are likely to cause residents psychological distress, make them feel as if they are not valued, and negatively impact resident comfort. The findings are: R #1 A. Record review of R #1's physician's orders revealed the following: 1. Order start date 11/25/24, order discontinue date 01/28/25: Resident to be toileted (assisted to the restroom to urinate and/or defecate) three times a day once in AM at the start of the shift. Once after dinner at the end of the shift and once in the evening PM shift. 2. Order start date 01/29/25: Resident to be toileted three times a day, once in AM at the start of the shift. Once after dinner at the end of the shift and once in the evening PM shift. A. On 02/12/25 at 11:15 AM, during an interview CNA #2, stated the following: 1. She is not assigned to work with R #1, but she has assisted staff with toileting R #1. 2. R #1 requires the assistance of two staff to toilet her due to her requiring a Hoyer lift (medical device lift designed to help caregivers safely transfer residents with limited mobility). 3. R #1 is unable to sit independently on the toilet once she is transferred to the toilet so one staff member stays with her while she is sitting on the toilet. B. On 02/12/25 at 1:55 PM, during an interview with RN #1, she stated she cannot ensure that R #1 is being toileted three times daily because she is the assigned nurse for 31 residents. C. On 02/12/25 at 4:17 PM, during an interview, CNA #1, stated the following: 1. R #1 requires the assistance of two staff to toilet her due to her requiring a Hoyer lift and her decreased mobility. 2. R #1 is usually assisted to the toilet three times daily. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R #1's Treatment Administration Record (TAR, electronic document where facility staff document ordered treatments) for December 2024 revealed the following: 1. Staff did not document that R #1 was assisted with toileting at 4:00 PM (dinner) on 12/02/24, 12/03/24 and 12/22/24. 2. Staff did not document that R #1 was assisted with toileting at 8:00 PM (evening) on 12/04/24. E. Record review of R #1's TAR, electronic document for January 2025 revealed staff did not document that R #1 was assisted with toileting at 4:00 PM (dinner) on 01/08/25, 01/23/25 and 01/31/25. R #3 F. On 02/11/25 at 2:30 PM, during an interview, R #3 stated the following: 1. She requires staff assistance to get in and out of bed. 2. She often waits 45 minutes to be assisted in or out of bed because the facility does not have enough staff to help all the residents that are dependent on staff. 3. There are several residents on her housing unit that require the assistance of two staff members (nine residents per the list provided by administrator on 02/11/25) due to needing a Hoyer lift. 4. Sometimes staff will come to her room turn off the call light and say they will be right back, but she ends up waiting another half hour or longer to be transferred. G. On 02/12/25 at 4:03 PM, during an interview RN #1 stated the following: 1. The facility is short-staffed, they need more CNA's to be able to meet the needs of all the residents that require the assistance of two staff. 2. Most recently, on 02/09/25, R #3's housing unit only had one CNA assigned because other staff were reassigned to assist on another housing unit. R #4 E. On 02/12/25 at 2:15 PM, during an interview, R #4 stated the following: 1. She requires a sit-to-stand (medical device that assists residents with limited mobility to be assisted in standing up from a seated position) to be transferred from her bed to her wheelchair and vice versa. 2. She often waits 30 minutes to one hour to be assisted in or out of bed because the facility has been short staffed. 3. There are several residents on her housing unit that require the assistance of two staff members due to Hoyer lifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 02/09/25 she had to eat breakfast and lunch in bed because there was only one nursing assistant (NA; nurse aid who has not taken a certification test) assigned to her housing unit. 5. She prefers to eat her meals in the dining room because she is a social butterfly and enjoys that time interacting with other residents. F. On 02/12/25 at 4:03 PM, during an interview with RN #1, she stated on 02/09/25, R #4's housing unit only had one NA assigned. The NA needs to get assistance from another staff member to assist R #4 out of bed using the sit-to-stand lift. R #5 G. On 02/13/25 at 2:55 PM, during an interview, R #5 stated the following: 1. She requires a Hoyer lift to be transferred from her bed to her wheelchair and vice versa. 2. She often waits over an hour to be assisted in or out of bed because the facility has been short staffed. 3. There are several residents on her housing unit that require the assistance of two staff members due to the use of a Hoyer lift. 4. Staff will sometimes come into her room and turn off the call light and will not return. 5. She has had to wait up to three hours to be assisted to bed after lunch. She does not like to stay in her chair too long because sitting to long hurts sometimes. H. On 02/12/25 at 4:34 PM, an interview, CNA #3 stated the following: 1. On 02/09/25 he and one other CNA were assigned to care for 34 residents, 15 of those residents require a Hoyer lift and two residents require assistance with a sit-to-stand. 2. There have been other times in the last two months (can't remember exact dates) that they were short staffed like they were on 02/09/25. 3. The assignment is too much for two CNA's due to the number of residents that require assistance from two CNA's due to the use of a Hoyer lift.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #16 and R #19) of 4 (R #16, R #17, R #18, and R #19) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are: R #16 A. Record review of R #16's admission record, no date, revealed R #16 was admitted to the facility on [DATE] with the following diagnoses: a. Metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance). b. Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy). c. Unspecified Dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and decision-making, severe enough to interfere with daily life and activities). d. Delirium (an acute state of mental confusion characterized by a rapid onset of altered consciousness, cognitive impairment, and changes in behavior and perception). e. Dysphagia (difficulty swallowing). f. Gastrostomy status (a surgical opening into the stomach for nutritional support) B. Record review of R #16's physician's order, dated [DATE], revealed an order for R #16 to receive 135 mL of water through an enteral route by feeding pump every four (4) hours. C. Record review of R #16's nursing administration record (NAR, spreadsheet where nurses initial to indicate the completion of a treatment), dated [DATE] revealed staff did not document that R #135 received 135 mL of water through his PEG tube on the following dates and times; 1. [DATE] at 4:00 AM and 8:00 PM 2. [DATE] at 12:00 AM and 4:00 PM 3. [DATE] at 4:00 AM and 8:00 PM 4. [DATE] at 12:00 AM and 4:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. [DATE] at 8:00 AM, 12:00 PM, and 4:00 PM 6. [DATE] at 8:00 PM 7. [DATE] at 12:00 AM, 4:00 AM, and 8:00 PM 8. [DATE] at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, and 4:00 PM 9. [DATE] at 4:00 AM 10. [DATE] at 8:00 PM D. Record review of R #16's nursing administration record (NAR, spreadsheet where nurses initial to indicate the completion of a treatment), dated [DATE] revealed staff did not document that R #135 received 135 mL of water through his PEG tube on the following dates and times; 1. [DATE] at 12:00 AM, 4:00 AM, 4:00 PM, and 8:00 PM 2. [DATE] at 12:00 AM and 4:00 AM 3. [DATE] at 8:00 PM 4. [DATE] at 12:00 AM and 4:00 AM 5. [DATE] at 8:00 AM, 12:00 PM, 4:00 PM 6. [DATE] at 8:00 PM 7. [DATE] at 12:00 AM, 4:00 AM, 8:00 PM E. On [DATE] at 11:26, during an interview, LPN #16 stated that the feeding pumps are programmed with resident's feeding orders and water flushes so the resident automatically receives the feeding as ordered and the water flushes as ordered. F. On [DATE] at 2:40 PM, during an interview, DON confirmed the following: 1. The nursing staff were expected to program the feeding pump to automatically administer ordered feeding amounts and water bolus (a method of administering liquid through a feeding tube in large, discrete amounts over a short period (typically ,d+[DATE] minutes) amounts. 2. Staff did not document several of R #16's ordered water bolus'. 3. Staff were expected to document all water bolus' that were administered during their shift. R #19 G. Record review of R #19's admission record, no date, revealed R #19 was admitted to the facility on [DATE]. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. Record review of R #19's electronic medication administration record note, dated [DATE], revealed resident was deceased . I. Record review of R #19's hospice nurse progress note, dated [DATE] at 1:08 PM, revealed the following: 1. R #19 passed (expired). 2. The nurse practitioner and nurse were notified. 3. R #19's family was grieving at bedside. J. Record review of R #19's entire medical record, no date, revealed the medical record did not contain documentation from facility staff regarding R #16's death. K. On [DATE] at 12:41 PM, during an interview with the ADON, she confirmed the following: 1. Staff did not document that R #19 had expired. 2. She was unable to determine what time R #19 expired. 3. Staff were expected to document information regarding the resident's death including who called the death, who was present at the time of death, and when the family and provider were notified regarding the resident's death.