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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Cruces Village Nursing & Rehabilitation LLC	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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to allow the resident the right to designate a representative and allow that representative the right to exercise the resident's rights to the extent those rights are delegated to the representative for 1 (R #1) of 3 (R #1, R #2, and R #3) residents sampled for residents rights, when the facility failed to allow R #1's POA (the legally appointed person (the agent or attorney-in-fact) to make decisions or act on their behalf regarding financial, legal, or medical matters) to obtain R #1's medical records. If resident representatives' decisions are not treated as that of a resident, then residents that do not have ability to make decisions for themselves are left with no one to advocate for their rights. The findings are:A. Record review of the State Agency Complaint Intake dated 03/24/26 revealed the following:R #1 had designated Family Member (FM) #1 as her POA.FM #1 was concerned about the care R #1 was receiving.FM #1 requested R #1's medical records before R #1 passed away.The facility never provided R #1's medical record. B. Record review of R #1's admission Record no date, revealed R #1 was admitted to the facility on [DATE]. C. Record review of R #1's care plan dated 03/10/25 revealed the following:1. R #1 had impaired cognitive function or impaired thought processes2. R #1 had a BIMS score of 5. D. Record review of R #1 POA form revealed the following:1. An effective date of 12/24/24.2. FM #1 had the authority to make decisions to: a. Long-term placement. b. Health care. c. Mental health including medications. d. Hospitalizations. E. Record review of R #1's nursing progress note dated 12/29/25 at 11:00 AM, revealed the following note: .RP [FM #1] returned out of room with Resident [R #1] while writer was speaking to ADON and approached ADON and writer stating, I am still waiting on medical records so I can sign whatever I need to sign to get my Mom's medical records. She is too busy on the phone. This is totally unacceptable. Look at my Mom. F. On 04/29/26 at 11:18 AM, during an interview LPN #1 stated that if family members want to request medical records they had to go to see Medical Records (MR). G. On 04/30/26 at 10:50 AM, during an interview MR confirmed the following:FM #1 did request to see R #1's medical records.MR gave her paperwork to fill out in order to get R #1 medical records twice.The first time FM #1 filled out the paperwork incorrectly.MR informed FM #1 that she needed to fill it out again. FM #1 did not give back the paperwork until after R #1 passed away.After a resident passes away the facility requests additional paperwork to release medical records.MR was aware FM #1 was R #1's POA and was able to act on her behalf.R #1 did not have the compacity to request medical records on her own.If it was a resident requested to have their medical records, they do not need to fill out paperwork. An oral request is sufficient.FM #1 never got R #1 medical records.

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the right to access personal and medical records pertaining to him or herself upon an oral or written request 1 (R #1) of 3 (R #1, R #2, and R #3) residents sampled for residents rights, when the facility failed to allow R #1's POA (the legally appointed person (the agent or attorney-in-fact) to make decisions or act on their behalf regarding financial, legal, or medical matters) [because R #1 did not have the capacity to on her own] to obtain R #1's medical record. If residents or their representatives acting on their behalf are not able to access their medical record, then they may not have the information needed to make healthcare decisions. The findings are:A. Record review of the State Agency Complaint Intake dated 03/24/26 revealed the following:R #1 had designated Family Member (FM) #1 as her POA.FM #1 was concerned about the care R #1 was receiving.FM #1 requested R #1's medical records before R #1 passed away.The facility never provided R #1's medical record. B. Record review of R #1's admission Record no date, revealed R 31 was admitted to the facility on [DATE]. C. Record review of R #1's care plan dated 03/10/25 revealed the following:1. R #1 had impaired cognitive function or impaired thought processes2. R #1 had a BIMS score of 5. D. Record review of R #1 POA form revealed the foolwoing:1. An effective date of 12/24/24.2. FM #1 had the authority to make decisions to: a. Long-term placement. b. Health care. c. Mental health including medications. d. Hospitalizations. E. Record review of the nursing progress notes dated 12/29/25 at 11:00 am, revealed the following note: .RP [FM #1] returned out of room with Resident while writer was speaking to ADON and approached ADON and writer stating, I am still waiting on medical records so I can sign whatever I need to sign to get my Mom's medical records. She is too busy on the phone. This is totally unacceptable. Look at my Mom. F. On 04/29/26 at 11:18 am, during an interview LPN #1 stated that if family members want to request medical records they had to go to see Medical Records (MR). G. On 04/30/26 at 10:50 am, during an interview MR confirmed the following:FM #1 did request to see R #1's medical records.MR gave her paperwork to fill out in order to get R #1 medical records twice.The first time FM #1 filled out the paperwork incorrectly.MR informed FM #1 that she needed to fill it out again. FM #1 did not give back the paperwork until after R #1 passed away.After a resident passes away the facility requests additional paperwork to release medical records.MR was aware FM #1 was R #1's POA and was able to act on her behalf.R #1 did not have the compacity to request medical records on her own.If it was a resident requested to have their medical record, they do not need to fill out paperwork. An oral request is sufficient.FM #1 never got R #1 medical records. H. Record review of the Determining Validity of Authorization for Release PHI (protected health information) facility policy revised date August 2020 revealed the following: I. The facility will use or disclose PHI pursuant to a valid authorization.II. The use or disclosure of PHI will be in a manner which is consistent with the authorization. I. Determining Which Disclosures Require an Authorization A. All requests from third party for release of PHI will go to the Medical Record Director. B. The Medical Records Director or his or her designee will determine whether the use or disclosure requires an Authorization from the resident.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interview, the facility failed to post the Ombudsman contact information in areas accessible to residents and their representatives this could affect all 89 residents in the facility (residents were identified by the census list provided by the Administrator on 04/29/26). If residents and their representatives are not aware of how to contact the Ombudsman, then they would not be aware of how contact the Ombudsman about concerns they have. The findings are:A. On 04/29/26 at 9:35 AM, during an observation of the facility, revealed staff did not have the Ombudsman information posted. B. On 04/29/26 at 10:00 AM, during an observation of the Activities Room, revealed staff placed an 8.5 x 11-inch paper roughly at eye level on the side refrigerator with the Ombudsman information on it. C. On 04/30/26 at 12:47 PM, during an interview, the Administrator confirmed that the facility took down the Ombudsman's posters so the facility could paint. The Administrator confirmed staff failed to put the Ombudsman's posters back up after completion.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure care plan revisions were completed for 1 (R #24) of 3 (R #24, R #25, and R #26) residents reviewed for care plans, when the staff failed to revise the care plan with the most current resident information for R #24. This deficient practice could likely result in care plans not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care being provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: A. Record review of R #24's admission record, no dated revealed R#24 was admitted to the facility on [DATE]. B. On 04/29/26 at 11:20 AM, during an interview, with R #24's Family Member (FM) stated the following: 1. Housekeeper #26 caused R #24 to fall in her room. 2. Housekeeper #26 should not have assisted R #24 because she's not a CNA in the Secure Unit. 3. FM did not want Housekeeper #26 to work in the Secure Unit around R #24. 4. The pervious Administrator and DON informed FM on 12/10/26 that Housekeeper #26 would not work in the Secure Unit anymore. 5. This was told to the current Administrator and DON when they started to work and the facility. C. Record review of R #24's care plan revision date 06/26/25, revealed staff did not document a revision that included R #24's FM request to keep Housekeeper #26 from contact or care with R #24 in the Secure Unit. D. On 04/29/26 at 12:52 PM, during an interview, the Housekeeping Supervisor (HS) stated Housekeeper #26 does not work in the Secure Unit due to R #24's FM not wanting Houskeeper #26 working in the Secure Unit around R #24. E. On 04/29/26 at 2:42 PM, during an interview Housekeeper #26 stated that she is no longer working in the Secure Unit. Houskeeper #26 stated she is not to be in contact or care for R #24. F. On 04/30/26 at 10:04 AM, during an interview with MDS Nurse stated she is the person that inputs information into the residents' care plans. The staff did not let her know about R #24's FM, not wanting Housekeeper #26 to be in contact with or care for R #24 in the Secure Unit. MDS nurse stated that any changes to resident's care should be inputted into the care plan. R #24's care plan was not updated with this information. G. On 04/30/26 at 12:30 PM, during an interview, the ADON stated she did not see anything in R #24's care plan regarding FM's wishes to keep Housekeeper #26 from contact or care with R #24 in the Secure Unit. The ADON stated it should have been in R #24's care plan.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to retain 18 months of records for the posted nurse staff information, this could affect all 89 residents in the facility (residents were identified by the census list provided by the Administrator on 04/29/26). If the facility does not retain 18 months of posted staffing, then residents or the public would have access to review. The findings are:A. On 04/29/26 at 8:54 AM, during an observation of the front lobby revealed the posted nursing staff information for the day. B. On 04/29/26 at 8:58 AM, during an interview, the DON stated she was new. She stated she was not sure the facility had 18 months of posted nursing staff information. C. On 04/30/26 at 12:47 PM, during an interview, the Administrator stated the facility was trying to get access to the posted nursing staff information but was unable to.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to secure a treatment cart for all 27 residents on the 500 and 600 unit (residents were identified by the census list provided by the Administrator on 04/29/26). This deficient practice could result in residents obtaining medication not prescribed to them resulting in adverse side effects. The findings are:A. On 04/29/26 at 8:40 am, during an observation, the nurses station revealed staff failed to secure a treatment cart on the 500/600 Unit. Staff were not present. B. On 04/29/26 at 8:44 am, during an interview, LPN #3 stated the treatment cart was unlocked. LPN #3 stated the treatment cart was the Treatment Nurse's (TN) cart. The TN was not on the unit. C. On 04/30/26 at 2:06 pm, during an interview, the [NAME] Consultant Nurse stated the treatment carts are supposed to be locked when not in use.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for all 89 resident in the facility (residents were identified by the census list provided by the Administrator on 04/29/26) randomly sampled residents, when they failed to ensure a floor drain sink in the [NAME] Janitors room was in operable working condition after the drain became clogged. This deficient practice could likely result in residents living in an environment that puts them at risk of waterborne pathogens such as Legionella contamination microorganisms, bacteria and fungi, which could grow in stagnate accumulating water. The findings are: A. On 04/30/26 at 8:45 AM, during an observation of the 400 Unit revealed the following: 1. Water was coming from the [NAME] Janitor room out into the hallway floor. 2. When Houskeeper #24 opened the door there was a clogged floor drain roughly 10 inches full of black dirty water. B. On 04/30/26 at 8:48 AM, during an interview with Housekeeper #24 stated the following: 1. She spilt some water in the hall in front of the janitor room when she was dumping out her mop bucket in the floor drain sink. 2. She mopped it up. 3. She stated that the drain is clogged. 4. The floor drain sink is where they dispose of their cleaning chemicals from their mop buckets. 5. She told her supervisor, but it hasn't been fixed it. 6. She stated it's been a while. C. On 04/30/26 at 10:10 AM, during an interview with the Housekeeping Supervisor (HS) stated she has made several work orders regarding the [NAME] Janitor room and the water overflow. Maintenance has not fixed it. The HS stated she and her staff have been unclogging the drain on their own for months. D. On 04/30/26 at 10:16 AM, during an interview the Maintenance Director (MD) stated the following: 1. Housekeeping takes care of their department, and if anything is needed, the supervisor will let him know. 2. He had no active orders regarding water overflow. 3. Housekeeping should have done a work order for the [NAME] Janitor room. 4. This type of black water can carry diseases such as: bacteria, mold, e coli, salmonella, that cause skin infections and could possibly cause Legionella in the water. E. On 04/30/26 at 10:30 AM, during an interview, the Administrator stated he expects the staff to place work orders as soon as they find issues in the facility. He stated he expects staff to report issues immediately so the facility can take care of the issue right away.