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	11/18/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the provider of abnormal vital signs (blood pressure and blood sugar) and that medication was not given for 3 (R #1, R #2, and R #9) of 3 (R #1, R #2, and R #9) residents reviewed for assessment and monitoring when staff failed to notify the provider that: 1. R #1 and R #2's blood pressure was low. 2. R #9's blood sugar was low. 3. Medication was held (not given) for R #1, R #2 and R #3. These deficient practices could likely result in residents not receiving necessary care or worsening medical conditions due to lack of or changes in treatment. The findings are: R #1A. Record review of R #1's admission record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of hypertensive heart disease with heart failure (condition in which high blood pressure has caused significant damage to the heart leading to the heart's inability to pump blood effectively). B. Record review of R #1's physician orders revealed the following: 1. Order dated 12/11/24, for amlodipine (medication used to hypertension by relaxing the heart vessels making it easier for heart to pump blood) 5 mg, give 1 tablet by mouth one time a day for hypertension (high blood pressure). 2. Order dated 12/13/24, for lisinopril (medication used to treat hypertension by relaxing the blood vessels which lowers blood pressure and increases blood flow to the heart) 20 mg, give 1 tablet by mouth one time a day for hypertension. C. Record review of R #1's medical record revealed the following: 1. On 06/23/25 staff documented medication held due to low parameters BP 77/55 heart rate (HR) 96. 2. On 06/26/25 staff documented resident's BP 97/51. 3. On 06/30/25 staff documented This medication is on hold due to resident's BP of 97/52 4. On 07/02/25 staff documented vitals outside of parameters for administration (specific predetermined measurements for vital signs set by physician/provider used to decide whether medication should be given or not). Staff did not document R #1's BP reading. 5. On 07/04/25 staff documented resident's BP 92/47. 6. On 07/07/25 staff documented vitals outside of parameters for administration. Staff did not document R #1's BP reading. 7. Medical record did not contain any documentation that the provider was notified of R #1's low blood pressure or that R #1's medication was held. R #2 D. Record review of R #2's admission record (no date) revealed the following: 1. R #2 was admitted to the facility on [DATE]. 2. R #2 had a diagnosis of hypertensive heart disease without heart failure (condition in which high blood pressure has caused significant damage to the heart but has not yet progressed to affect the heart's ability to pump blood effectively). E. Record review of R #2's physician orders revealed the following: 1. Order dated 11/08/23, for amlodipine 5 mg, give 2 tablets by mouth one time a day for hypertension, hold BP medication of systolic BP (top number of BP reading) is less than 100 or greater than 180 or if diastolic BP (bottom number of BP reading) is less than 50 or greater than 90. F. Record review of R #2's medical record revealed the following: 1. On 06/04/25 staff documented BP 90/60, vitals outside of parameters for administration. 2. On 06/05/25 staff documented BP 89/55, vitals outside of parameters for (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration. 3. On 06/10/25 staff documented BP 102/45, vitals outside of parameters for administration. 4. On 06/13/25 staff documented BP 83/46, vitals outside of parameters for administration. 5. On 06/14/25 staff documented BP 87/60, vitals outside of parameters for administration. 6. On 06/18/25 staff documented BP 95/51, vitals outside of parameters for administration. 7. On 06/20/25 staff documented BP 97/58, staff did not document whether medication was held or given. 8. On 07/01/25 staff documented this medication is on hold due to residents bp of 99/52. 9. On 07/19/25 staff documented this medication is on hold due to residents bp of 94/61. 10. On 07/25/25 staff documented BP 99/50, vitals outside of parameters for administration. 11. On 07/27/25 staff documented BP 89/59, vitals outside of parameters for administration. 12. On 07/30/25 staff documented BP 97/51, vitals outside of parameters for administration. 13. On 07/31/25 staff documented BP 98/42, vitals outside of parameters for administration. 14. Medical record did not contain any documentation that the provider was notified of R #2's low blood pressure or that R #2's medication was held. G. Record review of American Heart Association Low blood pressure-When blood pressure is too low last reviewed 05/06/24.www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure/low-blood-p revealed the following: 1. Low blood pressure occurs when blood pressure is less than 90/60. 2. Low blood pressure can happen with diuretics (medications that help the body eliminate excess fluid by increasing urine production) and other drugs used to treat high blood pressure. R #9 H. Record review of R #9's admission record (no date) revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 had a diagnosis of type 2 diabetes mellitus with hyperglycemia (chronic disease in which the body cannot use insulin properly and results in high blood sugar [BS] levels). I. Record review of R #9's physician orders revealed the following: 1. Order dated 08/28/25, for insulin glargine (medication used to improve and maintain blood sugar levels over an extended period of time) inject 28 units one time a day for diabetes mellitus type 2 (DM-2) 2. Order dated 08/22/25, for Humulin regular insulin (insulin that works to help lower blood sugar levels within 30 minutes of injection) inject as per sliding scale (insulin dosages that are adjusted based on the patient's current blood sugar level) before meals and at bedtime as follows: a. If BS level is 0-80 and conscious give 4 ounces of juice, if unconscious give glucagon (emergency medication used to treat severe low blood sugar in diabetes patients) 1 mg intramuscularly, notify doctor. b. If BS level is 81-199, no coverage (no insulin given). c. If BS level is 200-250 give 2 units. d. If BS level is 251-300 give 4 units. e. If BS level is 301-350 give 6 units. f. If BS level is 351-400 give 8 units. g. If BS level is 401 or greater give 10 units and notify doctor. J. Record review of the facility's Diabetic Management Policy dated 03/19/24 revealed the following: 1. ACUTE COMPLICATION MANAGEMENT: HYPOGLYCEMIA - Low Blood Sugar Levels a. If the BG (blood glucose/BS) level is below 70 mg/dl or other physician directed low parameter, and the resident can swallow, or the resident is tube fed: Give fast acting source of sugar and notify Medical Doctor (MD). b. Reassess the BG level in 15 minutes and document the results of the BG on the MAR. c. If the BG level remains below 70 mg/dl or other physician directed low parameter give: Additional source of sugar (e.g., another 4 ounces of orange juice or administer glucose gel. d. Recheck blood glucose in 15 minutes and document the results. e. Notify the physician of the episode. K. Record review of R #9's medical record revealed the following: 1. On 08/23/25 at 630 AM staff documented BS 70. 2. On 08/24/25 at 630 AM staff documented BS 80. 3. On 08/24/25 at 1130 AM staff documented BS 70. 4. On 08/25/25 at 430 PM staff documented BS 65. 5. On 08/25/25 at 830 PM staff documented BS 57. 6. On 08/26/25 at 1130 AM staff documented BS 62. 7. Medical record did not contain any documentation that the provider was notified of R #9's low blood sugar levels as indicated on R #9's physician's orders and as indicated in (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's Diabetic Management Policy. L. On 10/17/25 at 11:00 AM, during an interview, the DON confirmed the following: 1. Staff did not contact the provider to notify them of R #1's and R #2's low BP readings and holding BP medications. 2. Staff did not contact the provider to notify them of R #9's blood sugar levels as indicated in the order or the facility's Diabetic Management Policy. 3. Her expectation is that if staff have concerns regarding resident's vital signs and deciding to hold medications, they should contact the provider, document the conversation held with provider and enter a new order as needed depending on what the provider's decision is regarding the medication. 4. Staff should contact the physician as stated on the physician's orders. 5. Staff should follow facility's policy regarding contacting the provider.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception. They are used to treat a variety of conditions including anxiety, depression, bipolar disorder, and schizophrenia) unless the medication was medically necessary and had adequate monitoring for 2 (R #16 and R #24) of 3 (R #16, R #24, and R #25) residents reviewed for depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) treatment, when staff failed to: 1. Ensure 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) was carried out for R #16. 2. Adequately monitor for adverse side effects (unwanted, harmful, or abnormal result) of psychotropic medication for R #16 and R #24. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side. The findings are: Gradual Dose Reduction A. Record review of R #16's admission documents, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Dementia without behavioral disturbance (a condition where a person experiences cognitive decline, such as memory loss, difficulty with attention, and problem-solving, but does not exhibit significant behavioral changes or disturbances). b. Insomnia (a sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early in the morning, despite having adequate opportunity to sleep). c. Major depressive disorder (MDD), single episode (refers to a distinct episode of depression that meets the diagnostic criteria for MDD but occurs only once in the individual's lifetime). B. Record review of R #16's physician orders, multiple dates, revealed the following: 1. An order dated 10/17/24, for escitalopram oxalate (an antidepressant medication used primarily to treat MDD and generalized anxiety disorder) 20 mg, once a day for depression. 2. An order dated 10/17/24 for oxcarbazepine (an anticonvulsant medication primarily used to treat partial-onset seizures in adults and children) 300 mg, twice a day for anticonvulsant, and was discontinued on 05/17/25. 3. An order dated 05/17/25 for oxcarbazepine 300 mg, twice a day for depression. 4. An order dated 11/22/24 for trazadone (antidepressant medication that is also used to treat anxiety and insomnia) 25 mg, once a day for sleep aide. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. An order dated 06/29/25 for trazadone 25 mg, once a day for insomnia. C. Record review of R #16's PHQ-9 (a comprehensive, nine-question questionnaire that covers a wider range of depressive symptoms) assessment, multiple dates, revealed the following assessment scores (the PHQ-9 scoring ranges from 0 being no depression symptoms to 27 being severe depression symptoms): 1. On 10/17/24, R #16's score was 0. 2. On 12/29/24, R #16's score was 0. 3. On 01/24/25, R #16's score was 0. 4. On 04/26/25, R #16's score was 0. 5. On 07/28/25, R #16's score was 0. D. Record review of R #16's pharmacist recommendation dated 07/28/25, revealed the following: 1. R #16 had been taking escitalopram 20 mg once a day since 10/18/24. 2. The pharmacist recommended R #16 be evaluated to decrease the dose of escitalopram. 3. The provider selected resident with good response, maintain current dose. 4. The provider selected disagree with the pharmacist recommendation. 5. The provider did not document a clinical rationale for why R #16 should not have a dose reduction. E. Record review of R #16's entire medical record, no date, revealed the provider did not document a clinical rationale for why a GDR had not been conducted for R #16 for escitalopram 20 mg, oxcarbazepine 300mg, or trazadone 25 mg. F. On 10/09/25 at 2:04 PM, during an interview, LPN #16 stated R #16 did not have any symptoms of depression. G. On 10/09/25 at 3:32 PM, during an interview, the SSD confirmed R #16 always scored 0 on the PHQ-9 assessments, indicating he was not depressed. H. On 10/09/25 at 2:11 PM, during an interview, the DON confirmed the following: 1. R #16 had a diagnosis of MDD and insomnia. 2. R #16 had not shown any signs or symptoms of depression since admission. 3. R #16 was taking the same dose of escitalopram and oxcarbazepine since he arrived on 10/17/24. 4. R #16 was taking the same dose of trazadone since it was ordered on 11/22/24. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The provider had not conducted a GDR on escitalopram, oxcarbazepine, or trazadone. 6. The pharmacist recommended a GDR for escitalopram on 07/28/25 and the provider declined the GDR. 7. R #16's provider did not document a clinical rationale for why a GDR should not be conducted for escitalopram. 8. R #16's provider did not document a clinical for why a GDR should not be conducted for oxcarbazepine or trazadone. Monitoring R #16 I. Record review of R #16's physician's orders, multiple dates, revealed the following: 1. An order dated 10/17/24, for escitalopram oxalate, 20 mg, once a day for depression. 2. A black box warning (the most serious warning the U.S. Food and Drug Administration (FDA) can issue on drug and device labeling, alerting healthcare providers and patients to the risk of death or serious injury associated with the product) attached to the escitalopram order in the EMR system that stated closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 3. An order dated 06/29/25 for trazadone 25 mg, once a day for insomnia. 4. A black box warning (the most serious warning the U.S. Food and Drug Administration (FDA) can issue on drug and device labeling, alerting healthcare providers and patients to the risk of death or serious injury associated with the product) attached to the trazadone order in the EMR system that stated closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 5. An order dated 05/07/25, for behavior monitoring for compulsive behaviors. J. On 10/10/25 at 9:20 AM during an interview, LPN #17 stated the following: 1. R #16 had a black box warning for escitalopram and trazadone that indicated closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 2. R #16 was not being monitored for suicidal thoughts or suicidal behaviors. 3. R #16 was not being monitored for depression symptoms. 4. Staff must acknowledge black box warnings when they enter an order for a medication that has a black box warning. 5. She had never been instructed what to do when the black box warning pops up, so she just (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledges them. 6. She did not notify the provider about black box warnings when they popped up. K. On 10/10/25 at 12:05 PM, during an interview, the DON confirmed the following: 1. R #16's order for escitalopram had a black box warning that said, closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 2. R #16's order for trazadone had a black box warning that said, closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 3. Staff were not monitoring R #16 for suicidal thoughts or suicidal behaviors. 4. Staff were not monitoring R #16 for depression symptoms. 5. Staff were expected to notify the provider if a black box warning pops up. 6. Staff did not document in R #16's medical record whether the provider was notified about the black box warnings. 7. She was not sure if staff were expected to monitor residents for the signs or symptoms that were included in black box warnings. L. On 10/10/25 at 12:55 PM, during an interview, the Psychiatric Nurse Practitioner (PNP) confirmed the following: 1. He would expect staff to monitor all residents who were taking anti-depressants for worsening of depressive symptoms and suicidal thoughts and behaviors. 2. He was not notified about the black box warning on R #16's escitalopram or trazadone. 3. He would expect residents to be monitored for suicidal thoughts and suicidal behaviors if there was a black box indicating they should be monitored. R #24 M. Record review of R #24's admission Record, no date, revealed R #24 was admitted on [DATE] with the following diagnoses. 1. Other specified Depressive Episodes (refer to a category that applies to individuals who exhibit symptoms characteristic of a depressive disorder but do not meet the full criteria for any specific depressive disorder.) 2. Mild Neurocognitive Disorder due to known physiological condition with behavioral disturbance (also known as Mild Cognitive Impairment, is a condition in which individuals demonstrate cognitive impairment with minimal impairment of instrumental activities of daily living.) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Major Depressive Disorder recurrent, severe with Psychotic symptoms. 4. Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety. N. Record review of R #24's physician orders revealed an order dated 07/02/25 for Duloxetine HCl (a selective serotonin and norepinephrine reuptake inhibitor used to treat major depressive disorder, generalized anxiety disorder, and certain types of chronic pain) oral capsule delayed release give 1 capsule by mouth at bedtime for major depressive disorder, recurrent, severe with psychotic symptoms. The black box warning associated with R #24's Duloxetine medication in physicians orders reads as follows: 1. Suicidal thoughts and behavior. 2. Monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. O. Record review of R #24's MAR, dated 10/01/25-10/31/25 revealed the following behaviors and anti-psychotic interventions monitored for psychosis every shift for use of antipsychotic medication in R #24's MAR as follows: 1. Monitor behaviors of psychosis every shift for use of antipsychotic medication: a. Yelling, b. screaming, c. refusing care, d. refusing medication, e. false accusations. 2. Anti-psychotic interventions: 1. allow to express feelings, 2. offer emotional support, 3. redirect resident, 4. two times a day for monitoring. P. Record review of R #24's entire medical record, no date, revealed R #24 did not have any documentation for monitoring suicidal thoughts and suicidal behaviors for the medication Duloxetine HCl (used to treat major depressive disorder.) Q. On 10/10/25 at 1:45 PM during an interview with LPN #26 stated, she is documenting the interventions and monitoring R #24's antipsychotic medication in R #24's MAR when she works with R #24. LPN (continued on next page)

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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** Based on record review and interview, the facility failed to develop and implement accurate, person-centered comprehensive care plan for 1 (R #16) of 3 (R #16, R #24, and R #25) residents reviewed for depression when staff failed to: 1. Include what behaviors staff were expected to monitor for related to his diagnosis of depression. 2. Include non-pharmacological interventions for R #16's diagnosis of depression. These deficient practices could likely result in staff being unaware of the current and actual needs of the residents. The findings are: A. Record review of R #16's admission documents, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had a diagnosis of major depressive disorder (MDD), single episode (refers to a distinct episode of depression that meets the diagnostic criteria for MDD but occurs only once in the individual's lifetime). B. Record review of R #16's physician's orders, multiple dates, revealed the following: 1. An order dated 10/17/24, for escitalopram oxalate (an antidepressant medication used primarily to treat MDD and generalized anxiety disorder) 20 mg, once a day for depression. 2. A black box warning (the most serious warning the U.S. Food and Drug Administration (FDA) can issue on drug and device labeling, alerting healthcare providers and patients to the risk of death or serious injury associated with the product) attached to the escitalopram order in the EMR system that stated closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 3. An order dated 10/17/24 for oxcarbazepine (an anticonvulsant medication primarily used to treat partial-onset seizures in adults and children) 300 mg, twice a day for anticonvulsant, and was discontinued on 05/17/25. 4. An order dated 05/17/25 for oxcarbazepine 300 mg, twice a day for depression. 5. An order dated 05/07/25, for behavior monitoring for compulsive behaviors. C. Record review of R #16's progress notes, multiple dates, revealed the following: 1. On 11/04/24, R #16 was making sexually inappropriate verbal comments towards female staff. 2. On 12/24/24, staff documented that R #16 became frustrated and very upset with staff. R #16 was cussing under his breath and was not easily redirected (a proactive strategy to guide a child away from challenging or undesirable actions toward more positive and acceptable ones before the behavior escalates). 3. On 12/29/24, staff documented R #16 was agitated throughout shift. 4. On 04/08/25, staff documented that R #16 had been having inappropriate behaviors toward female staff. 5. On 04/26/25, social services progress note, staff documented that R #16 continued to have negative sexual behaviors toward female staff. 6. On 04/27/25, staff documented that R #16 had sexual behaviors. 7. On 07/11/25, staff documented that R #16 had sexual behaviors toward a female resident and female staff member. 8. On 07/20/25, staff documented that R #16 had been talking about having sexual relations with staff and residents. Staff notified the on-call provider. The on-call provider ordered a psychiatric referral. 9. On 07/21/25, staff documented that R #16 stated he wasn't feeling well due to staff saying he was having sexual behaviors. 10. On 09/14/25, staff documented that R #16 was sexually inappropriate with female residents in his room. D. Record review of R #16's care plan, revised on 05/29/25, revealed the following: 1. Staff documented that R #16 behavior should be monitored. 2. Staff did not document what behaviors R #16 should be monitored for related to depression diagnosis or anti-depressant medication. 3. Staff did not document what non-pharmacological interventions staff were expected to implement for R #16's diagnosis of depression. 4. Staff did not document what compulsive behaviors R #16 had that needed to be monitored. 5. Staff did not document what interventions staff were expected to implement when R #16 exhibited compulsive behaviors. 6. Staff did not document that R #16 had sexually inappropriate behaviors with female staff and female residents. E. On 10/10/25 at 9:20 AM during an (continued on next page)

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	11/18/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview, LPN #17 stated the following: 1. R #16 was taking an anti-depressant for depression. 2. R #16 had a black box warning for escitalopram and trazadone orders that indicated closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 3. R #16 was not monitored for suicidal thoughts or suicidal behaviors. 4. R #16 was not monitored for depression symptoms. 5. R #16 did not have any non-pharmacological interventions in place for his diagnosis of depression. 6. R #16 was being monitored for inappropriate sexual behaviors toward female staff and female residents. F. On 10/10/25 at 12:05 PM, during an interview, the DON confirmed the following: 1. R #16's order for escitalopram had a black box warning that said, closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. 2. R #16's care plan did not include any specific behaviors related to depression that staff should monitor for. 3. R #16's care plan did not include any non-pharmacological interventions for his diagnosis of depression. 4. R #16's care plan did not include for staff to monitor R #16 for worsening depression or emergence of suicidal thoughts or suicidal behaviors. 5. Staff should include what interventions are in place to treat depression on the care plan. 6. Staff should include what behaviors residents were being monitored for on the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to meet professional standards of practice (established guidelines and expectations that ensure the delivery of high-quality care to residents) for 3 (R #1, R #2 and R #9) of 3 (R #1, R #2 and R #9) residents reviewed for assessment and monitoring when facility staff failed to: 1. Administer medications as ordered for R #1, R #2 and R #9. 2. Contact the provider to notify them when medication was held due to possible adverse effects (unintended effect that is undesirable, unpleasant, or harmful) of medication for R #1, R #2 and R #9. If the facility is not providing care per physician's orders, notifying the provider of changes and providing care that meets professional standards of practice, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: R #1 A. Record review of R #1's admission record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of hypertensive heart disease with heart failure (condition in which high blood pressure has caused significant damage to the heart leading to the heart's inability to pump blood effectively). B. Record review of R #1's physician orders revealed the following: 1. Order dated 12/11/24, for amlodipine (medication used to hypertension by relaxing the heart vessels making it easier for heart to pump blood) 5 mg, give 1 tablet by mouth one time a day for hypertension (high blood pressure). 2. Order dated 12/13/24, for lisinopril (medication used to treat hypertension by relaxing the blood vessels which lowers blood pressure and increases blood flow to the heart) 20 mg, give 1 tablet by mouth one time a day for hypertension. 3. The physician orders did not contain an order to hold medications based on specific parameters (specific predetermined measurements for vital signs [blood pressure] set by physician/provider used to decide whether medication should be given or not). C. Record review of R #1's medication administration record (MAR; a form used to document medication administration) dated June 2025, revealed the following: -amlodipine 1. On 06/23/25 staff documented 5 = hold (do not give medication)/see progress notes. 2. On 06/26/25 staff documented 5. 3. On 06/30/25 staff documented 5. -lisinopril 4. On 06/23/25 staff documented 5. 5. On 06/26/25 staff documented 5. 6. On 06/30/25 staff documented 5. D. Record review of R #1's medication administration record dated July 2025, revealed the following: -amlodipine 1. On 07/02/25 staff documented 4 = vitals outside of parameters for administration (specific predetermined measurements for vital signs [blood pressure] set by provider indicating when medication is to be held) 2. On 07/04/25 staff documented 5. 3. On 07/07/25 staff documented 4. -lisinopril 4. On 07/02/25 staff documented 4. 5. On 07/04/25 staff documented 5. 6. On 07/07/25 staff documented 4. E. Record review of R #1's progress notes for June 2025 revealed the following: 1. Staff did not document they notified the provider regarding holding R #1's BP medication. 2. On 06/23/25 staff documented medication held due to low parameters BP 77/55 heart rate (HR) 96. 3. On 06/26/25 staff documented resident's BP 97/51. 4. On 06/30/25 staff documented This medication is on hold due to resident's BP of 97/52 F. Record review of R #1's progress notes for July 2025 revealed the following: 1. Staff did not document they notified the provider regarding holding R #1's BP medication. 2. On 07/02/25 staff did not document what R #1's BP reading was or why BP medication was held. 3. On 07/04/25 staff documented resident's BP 92/47. 4. On 07/07/25 staff did not document what R #1's BP reading was or why BP medication was held. R #2 G. Record review of R #2's admission record (no date) revealed the following: 1. R #2 was admitted to the facility on [DATE]. 2. R #2 had a diagnosis of hypertensive heart disease without heart failure (condition in which high blood pressure has caused significant damage to the heart but has not yet progressed to affect the heart's ability to pump (continued on next page)

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	325039	A. Building B. Wing	11/18/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood effectively). H. Record review of R #2's physician orders revealed the following: 1. Order dated 11/08/23, for amlodipine 5 mg, give 2 tablets by mouth one time a day for hypertension, hold BP medication of systolic BP (top number of BP reading) is less than 100 or greater than 180 or if diastolic BP (bottom number of BP reading) is less than 50 or greater than 90. I. Record review of R #2's MAR dated June 2025, revealed the following: -amlodipine 1. R #2's blood pressure medication was held 18 out of 30 days in June 2025. 2. On 06/02/25 staff documented 4 but staff did not document R #2's BP reading or HR. 3. On 06/04/25 staff documented 4 BP 90/60, HR 62. 4. On 06/05/25 staff documented 4 BP 89/55, HR 74. 5. On 06/06/25 staff documented 4 BP 117/59, HR 52. 6. On 06/09/25 staff documented 4 BP 108/53, HR 78. 7. On 06/10/25 staff documented 4 BP 102/45, HR 59. 8. On 06/12/25 staff documented 4 BP 101/57, HR 58. 9. On 06/13/25 staff documented 4 BP 83/46, HR 72. 10. On 06/14/25 staff documented 4 BP 87/60 HR 54. 11. On 06/16/25 staff documented 9 = Other/See progress notes but staff did not document R #2's BP reading or HR. 12. On 06/18/25 staff documented 4 BP 95/51 HR 110. 13. On 06/20/25 staff documented 5 BP 97/58, HR 61. 14. On 06/22/25 staff documented 5 but staff did not document R #2's BP reading or HR. 15. On 06/23/25 staff documented 4 BP 118/62, HR 67. 16. On 06/24/25 staff documented 4 BP 100/55, HR 91. 17. On 06/27/25 staff documented 4 but staff did not document R #2's BP reading or HR. 18. On 06/28/25 staff documented 4 but staff did not document R #2's BP reading or HR. 19. On 06/29/25 staff documented 4 but staff did not document R #2's BP reading or HR. J. Record review of R #2's MAR dated July 2025, revealed the following: -amlodipine 1. R #2's blood pressure medication was held 19 out of 31 days in July 2025. 2. On 07/01/25 staff documented 5 BP 99/52, HR 47. 3. On 07/02/25 staff documented 4 but staff did not document R #2's BP reading or HR. 4. On 07/03/25 staff documented 5 but staff did not document R #2's BP reading or HR. 5. On 07/04/25 staff documented 5 BP 104/59, HR 47. 6. On 07/07/25 staff documented 4 but staff did not document R #2's BP reading or HR. 7. On 07/08/25 staff documented 4 but staff did not document R #2's BP reading or HR. 8. On 07/12/25 staff documented 4 but staff did not document R #2's BP reading or HR. 9. On 07/13/25 staff documented 4 BP 103/87, HR 76. 10. On 07/14/25 staff documented 9 but staff did not document R #2's BP reading or HR. 11. On 07/16/25 staff documented 4 but staff did not document R #2's BP reading or HR. 12. On 07/18/25 staff documented 5 but staff did not document R #2's BP reading or HR. 13. On 07/19/25 staff documented 5 BP 94/61, HR 59. 14. On 07/21/25 staff documented 4 but staff did not document R #2's BP reading or HR. 15. On 07/22/25 staff documented 4 but staff did not document R #2's BP reading or HR. 16. On 07/23/25 staff documented 4 BP 105/59, HR 54. 17. On 07/25/25 staff documented 4 BP 99/50, HR 69. 18. On 07/27/25 staff documented 4 BP 89/59, HR 61. 19. On 07/30/25 staff documented 4 BP 97/51, HR 77. 20. On 07/31/25 staff documented 4 BP 98/42, HR 54. K. Record review of R #2s progress notes for June 2025 revealed the following: 1. Staff did not document they notified the provider regarding holding R #2's amlodipine for several days. 2. On 06/02/25 staff did not document R #2's blood pressure or the reason the amlodipine was held. 3. On 06/05/25 staff documented hold medication per nurse, BP and HR low. 4. On 06/06/25 and 06/09/25 staff did not document regarding holding amlodipine even though the documented BP readings on the MAR were within the parameters to give the medication. 5. On 06/12/25 staff documented hold medication BP was low, staff did not document communication to the provider to determine the need to hold medication even though the documented BP reading was within the parameters to give. 6. On 06/13/25 staff did not document any communication to the provider regarding significantly low BP of 83/46. 7. On 06/14/25 staff documented amlodipine held due to low parameters. No documentation that the provider was informed that R #2's BP remained low at 87/60. 8. On 06/16/25 staff did not document R #2's BP reading and documented patient had an appointment. No documentation that provider was notified that R #2 missed (continued on next page)

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	325039	A. Building B. Wing	11/18/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his medication due to being at an appointment. 9. On 06/22/25 staff documented resident's BP 99/56, HR 53. 10. On 06/23/25 and 06/24/25 staff did not document regarding holding amlodipine even though the documented BP readings on the MAR were within the parameters to give the medication. 11. On 06/27/25, 06/28/25 and 06/29/25 staff did not document R #2's BP readings or the reason that amlodipine was held. L. Record review of R #2's progress notes for July 2025 revealed the following: 1. Staff did not document that they notified the provider regarding holding R #2's medication for several days. 2. On 07/02/25 staff did not document what R #2's blood pressure reading was or why amlodipine was held. 3. On 07/03/25 staff documented resident's BP 99/54. 4. On 07/04/25 staff documented amlodipine is on hold due to resident's pulse (Heart rate/HR) of 47. Documentation did not include whether the provider was consulted or notified of low HR since R #2's amlodipine order does not have HR parameters indicating when to hold the medication. 5. On 07/07/25, 07/08/25 and 07/12/25 staff did not document R #2's BP or the reason why amlodipine was held. 6. On 07/13/25 staff did not document regarding holding amlodipine even though the documented BP reading on the MAR was within the parameters to give the medication. 7. On 07/14/25 staff did not document R #2's BP reading and documented resident is out of facility on transport, reported to charge nurse. No documentation that provider was notified that R #2 missed his medication due to being at an appointment. 8. On 07/16/25 staff did not document R #2's BP reading or the reason why amlodipine was held. 9. On 07/18/25 staff documented resident's BP 95/55, HR 63. 10. On 07/21/25 and 07/22/25 staff did not document R #2's BP or the reason why amlodipine was held. 11. On 07/23/25 staff documented BP and HR low, nurse notified staff did not document why amlodipine was held even though the documented BP reading on the MAR was within the parameters to give the medication. M. Record review of American Heart Association Low blood pressure-When blood pressure is too low last reviewed 05/06/24.www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure/low-blood-p revealed the following: 1. Low blood pressure occurs when blood pressure is less than 90/60. 2. Low blood pressure can happen with diuretics (medications that help the body eliminate excess fluid by increasing urine production) and other drugs used to treat high blood pressure. R #9 N. Record review of R #9's admission record (no date) revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 had a diagnosis of type 2 diabetes mellitus with hyperglycemia (chronic disease in which the body cannot use insulin properly and results in high blood sugar [BS] levels). O. Record review of R #9's physician orders revealed the following: 1. Order dated 08/28/25, for insulin glargine (medication used to improve and maintain blood sugar levels over an extended period of time) inject 28 units one time a day for diabetes mellitus type 2 (DM-2) 2. Order dated 08/22/25, for Humulin regular insulin (insulin that works to help lower blood sugar levels within 30 minutes of injection) inject as per sliding scale (insulin dosages that are adjusted based on the patient's current blood sugar level) before meals and at bedtime as follows: a. If BS level is 0-80 and conscious give 4 ounces of juice, if unconscious give glucagon (emergency medication used to treat severe low blood sugar in diabetes patients) 1 mg intramuscularly, notify doctor. b. If BS level is 81-199, no coverage (no insulin given). c. If BS level is 200-250 give 2 units. d. If BS level is 251-300 give 4 units. e. If BS level is 301-350 give 6 units. f. If BS level is 351-400 give 8 units. g. If BS level is 401 or greater give 10 units and notify doctor. P. Record review of R #9's MAR dated August 2025, revealed the following: -insulin glargine 1. On 08/20/25 staff documented 13 medication not available. 2. On 08/21/25 staff documented 5. 3. On 08/25/25 staff documented 5. 4. On 08/26/25 staff documented 6 = hospitalized -Humulin 5. On 08/23/25 at 630 AM staff documented 4 BS 70. 6. On 08/24/25 at 630 AM staff documented 4 BS 80. 7. On 08/24/25 at 1130 AM staff documented 9, staff did not document BS (continued on next page)

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	325039	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level. 8. On 08/24/25 at 430 PM staff documented 4 BS 70. 9. On 08/25/25 at 430 PM staff documented 4 BS 65. 10. On 08/25/25 at 830 PM staff documented 4 BS 57. 11. On 08/26/25 at 1130 AM staff documented 4 BS 62. Q. Record review of Diabetic Management Policy dated 03/19/24 revealed the following: 1. ACUTE COMPLICATION MANAGEMENT: HYPOGLYCEMIA - Low Blood Sugar Levels a. If the BG (blood glucose/BS) level is below 70 mg/dl or other physician directed low parameter, and the resident can swallow, or the resident is tube fed: Give fast acting source of sugar and notify MD. b. Reassess the BG level in 15 minutes and document the results of the BG on the MAR. c. If the BG level remains below 70 mg/dl or other physician directed low parameter give: Additional source of sugar (e.g., another 4 ounces of orange juice or administer glucose gel. d. Recheck blood glucose in 15 minutes and document the results. e. Notify the physician of the episode. R. Record review of R #9's progress notes for August 2025 revealed the following: 1. On 08/21/25 staff did not document R #9's BS level or the reason why insulin glargine was held. 2. On 08/25/25 for insulin glargine, staff documented blood glucose low. Staff did not consult the provider regarding holding the medication since the medication does not have hold parameters. 3. On 08/23/25, 08/24/25, 08/25/25 and 08/26/25 staff did not document that they gave juice, glucagon, rechecked the BS level or notified the provider of R #9's BS levels of 80 or less. S. On 10/17/25 at 11:00 AM, during an interview, the DON confirmed the following: 1. Staff did not contact the provider to notify them of R #1's and R #2's BP medications being held. 2. R #1's amlodipine and lisinopril orders did not have parameters indicating when the medications should be held. 3. R #2's amlodipine was held outside of set parameters. 4. R #9's insulin glargine was held, and the order did not have parameters indicating when to hold the medication. 5. Staff did not follow R #9's Humulin insulin order or the facility policy regarding low blood sugars. 6. Her expectation is that if staff have concerns regarding administering medications, they contact the provider, document the conversation held with provider and enter a new order as needed depending on what the provider's decision is regarding the medication.

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	325039	A. Building B. Wing	11/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet quality of care standards for 1 (R #9) of 3 (R #1, R #2, and R #9) residents reviewed for diabetes (chronic disease in which the body cannot use insulin properly and results in high blood sugar [BS] levels) when staff did not obtain finger stick blood glucose levels for R #9 upon return to the facility. This deficient practice could likely result in complications related to diabetes. The findings are: A. Record review of R #9's admission record (no date) revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 had a diagnosis of type 2 diabetes mellitus with hyperglycemia (DM2; chronic disease in which the body cannot use insulin properly and results in high blood sugar [BS] levels). B. Record review of R #9's nursing progress notes revealed the following: 1. R #9 was sent to the hospital on [DATE] due to a fall at the facility. 2. R #9 was admitted to the hospital from [DATE] through 08/31/25. C. Record review of R #9's convalescent care orders (CCO; discharge orders from the hospital for residents entering long-term care facilities), dated 08/31/25, revealed the following: 1. Treatment Orders: For patients with diabetes and accuchecks (routine blood glucose checks ordered for patients) a. Accuchecks before meals and at bedtime (AC and HS; blood glucose checks performed before meals and at bedtime to manage diabetes effectively.)? Was answered Yes. D. Record review of R #9's provider progress notes revealed the following: 1. R #9 was seen by the facility provider on 09/03/25. 2. Under diagnosis, assessment, plan provider documented the following: a. Diabetes mellitus type 2, continue blood sugar checks before meals and at bedtime. E. Record review of R #9's physician's orders revealed no order for accuchecks/blood sugar checks was entered as indicated on the CCO and providers progress note for 09/03/25. F. Record review of R #9's blood sugar summary (vital sign section where staff document blood glucose levels) revealed no blood glucose checks were completed by staff after 08/26/25. G. On 10/16/25 at 2:31 PM, during an interview with the provider, he confirmed he did want R #9 to be on blood glucose checks upon his readmission from the hospital. He was unaware that this order had not been implemented upon R #9's return from the hospital.

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	325039	A. Building B. Wing	11/18/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure residents received necessary behavioral health care to meet their needs for 1 (R #16) of 3 (R #16, R #24, and R #25) residents reviewed for behavioral health concerns when: 1. Staff delayed psychiatric services for R #16 after a psychiatric referral on 12/18/24 and 07/20/25. 2. Staff failed to refer R #16 for recommended therapy services on 03/14/25. 3. Staff did not have an effective process for referring residents to behavioral health services. These deficient practices could likely result in residents not receiving the behavioral or mental health care and assistance needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The findings are: A. Record review of R #16's admission documents, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Parkinson's Disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination). b. Dementia without behavioral disturbance (a condition where a person experiences cognitive decline, such as memory loss, difficulty with attention, and problem-solving, but does not exhibit significant behavioral changes or disturbances). c. Insomnia (a sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early in the morning, despite having adequate opportunity to sleep). d. Major depressive disorder (MDD), single episode (refers to a distinct episode of depression that meets the diagnostic criteria for MDD but occurs only once in the individual's lifetime). B. Record review of R #16's physician's orders, multiple dates, revealed the following: 1. An order dated 10/17/24, for escitalopram oxalate (an antidepressant medication used primarily to treat MDD and generalized anxiety disorder) 20 mg, once a day for depression. 2. An order dated 10/17/24 for oxcarbazepine (an anticonvulsant medication primarily used to treat partial-onset seizures in adults and children) 300 mg, twice a day for anticonvulsant, and was discontinued on 05/17/25. 3. An order dated 05/17/25 for oxcarbazepine 300 mg, twice a day for depression. 4. An order dated 12/18/24, to refer R #16 to [Name of psychiatric provider] for evaluation and treatment. 5. An order dated 05/07/25, for behavior monitoring for compulsive behaviors. 6. An order dated 07/20/25, for psych consult due to inappropriate sexual behaviors. C. Record review of R #16's progress notes, multiple dates, revealed the following: 1. On 11/04/24, R #16 was making sexually inappropriate verbal comments towards female staff. 2. On 12/24/24, staff documented that R #16 became frustrated and very upset with staff. R #16 was cussing under his breath and was not easily redirected (a proactive strategy to guide a child away from challenging or undesirable actions toward more positive and acceptable ones before the behavior escalates). 3. On 12/29/24, staff documented R #16 was agitated throughout shift. 4. On 04/08/25, staff documented R #16 had been having inappropriate behaviors toward female staff. 5. On 04/26/25, on the quarterly social services evaluation progress note, staff documented that R #16 continued to have negative sexual behaviors toward female staff. 6. On 04/27/25, staff documented R #16 had sexual behaviors. 7. On 07/11/25, staff documented R #16 had sexual behaviors toward a female resident and female staff member. 8. On 07/20/25, staff documented R #16 had been talking about having sexual relations with staff and residents. Staff notified the on-call provider. The on-call provider ordered a psychiatric referral. 9. On 07/21/25, staff documented R #16 stated he wasn't feeling well due to staff saying he was having sexual behaviors. 10. On 09/14/25, staff documented R #16 was sexually inappropriate with female residents in his room. 11. On 10/06/25, staff documented R #16 had self-harm and the psychiatric provider was notified. D. Record review of R #16's administration record (method for staff to document treatments or behaviors), dated July 2025, revealed staff documented R #16 had compulsive behaviors on (continued on next page)

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	11/18/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following dates: 1. 07/09/25. 2. 07/20/25. E. Record review of R #16's administration record, dated August 2025, revealed staff documented R #16 had compulsive behaviors on the following dates: 1. 08/05/25 2. 08/06/25 F. Record review of R #16's administration record, dated September 2025, revealed staff documented R #16 had compulsive behaviors on the following dates: 1. 09/08/25 2. 09/14/25 G. Record review of R #16's provider progress notes, multiple dates, revealed the following: 1. On 05/23/25, the provider documented that R #16 had depression and was not followed by psychiatry. 2. On 07/01/25, the provider documented that R #16 had a diagnosis of depression and was not followed by psychiatry. 3. On 08/23/25, the provider documented that R #16 had a diagnosis of depression and was not followed by psychiatry. H. Record review of R #16's Psychiatric Evaluation (a comprehensive assessment of an individual's mental health status conducted by a qualified mental health professional, such as a psychiatrist, psychologist, or social worker), multiple dates, revealed R #16 was seen on: 1. 03/14/25, the psychiatric provider recommended R #16 continue therapy services (resident was not receiving therapy services at that time, see finding I and M). 2. 10/06/25, after an episode of self-harm. I. Record review of R #16's entire medical record, no date, revealed R #16 was not seen for therapy services at the facility. J. On 10/10/25 at 9:20 AM during an interview, LPN #17 stated the following: 1. R #16 was taking an anti-depressant for a diagnosis of depression. 2. R #16 did not have any non-pharmacological interventions in place for his diagnosis of depression. 3. She was unsure if R #16 was receiving behavioral health services. 4. R #16 frequently exhibited sexual behaviors toward female staff and female residents. 5. Staff were monitoring R #16 for his sexual behaviors toward female staff and female residents. 6. R #16's order to monitor compulsive behaviors was related to sexual behaviors. 7. She was the nurse working when R #16 had an episode of self-harm on 10/06/25. 8. R #16 had never stated suicidal thoughts or showed suicidal behaviors prior to 10/06/25. K. On 10/10/25 at 10:02 AM, during an interview, the SSD stated the following: 1. R #16 had a referral for [Name of psychiatric company] on 12/18/24. 2. R #16 was not seen by the psychiatric provider until 03/14/25. 3. She stated that when a referral is placed for a psychiatric provider, the nurses were expected to verbally notify her, then she sends the referral to the psychiatric provider. 4. R #16 had another referral, dated 07/20/25, for a psychiatric consult due to increased sexual behaviors. 5. R #16 was not seen by the psychiatric provider until 10/06/25. 6. She stated she did not have a method to track when she was verbally notified about psychiatric referrals. L. On 10/10/25 at 12:05 PM, during an interview, the DON confirmed the following: 1. Staff were expected to verbally notify the SSD when a psychiatric referral was ordered. 2. The SSD was expected to send the referral to the psychiatric provider. 3. There was no tracking method to ensure the SSD was notified and the referral was sent to the psychiatric provider. 4. Her expectation was for nursing staff to notify the psychiatric provider if a resident is having increased behaviors. 5. She was unable to determine when the SSD was notified about R #16's referrals on 12/18/24 or 07/20/25. 6. R #16 was seen by the psychiatric provider on 03/14/25 and after his episode of self-harm on 10/06/25. M. On 10/10/25 at 12:20 PM, during an interview, the Medical Records Director confirmed R #16 was not being seen for counseling. N. On 10/10/15 at 12:55 PM, during an interview, the psychiatric nurse practitioner (PNP) confirmed the following: 1. He usually received referrals from the SSD via email. 2. He was unsure when he was notified about R #16's first referral on 12/18/24. 3. He saw R #16 on 03/14/25. 4. He was not notified that a new referral for R #16 was placed on 07/20/25. 5. He was not notified that R #16 had sexual behaviors. 6. If he had been notified about R #16 having sexual behaviors, he would have followed up with him. 7. He saw R #16 after an episode of self-harm on 10/06/25. 8. He confirmed he did not see R #16 between the 03/14/25 and 10/06/25 visits.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician provided documentation of a rationale (set of reasons or a logical basis for a course of action) for not following the consultant pharmacist's recommendation for 1 (R #16) of 3 (R #16, R #24, and R #25) residents reviewed for depression. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). A. Record review of R #16's admission documents, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Dementia without behavioral disturbance (a condition where a person experiences cognitive decline, such as memory loss, difficulty with attention, and problem-solving, but does not exhibit significant behavioral changes or disturbances). b. Insomnia (a sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early in the morning, despite having adequate opportunity to sleep). c. Major depressive disorder (MDD), single episode (refers to a distinct episode of depression that meets the diagnostic criteria for MDD but occurs only once in the individual's lifetime). B. Record review of R #16's physician's orders, multiple dates, revealed the following: 1. An order dated 10/17/24, for escitalopram oxalate (an antidepressant medication used primarily to treat MDD and generalized anxiety disorder) 20 mg, once a day for depression. 2. An order dated 10/17/24 for oxcarbazepine (an anticonvulsant medication primarily used to treat partial-onset seizures in adults and children) 300 mg, twice a day for anticonvulsant, and was discontinued on 05/17/25. 3. An order dated 05/17/25 for oxcarbazepine 300 mg, twice a day for depression. 4. An order dated 11/22/24 for trazadone (antidepressant medication that is also used to treat anxiety and insomnia) 25 mg, once a day for sleep aide. 5. An order dated 06/29/25 for trazadone 25 mg, once a day for insomnia. C. Record review of R #16's pharmacist recommendation, dated 07/28/25, revealed the following: 1. R #16 had been taking escitalopram 20 mg once a day since 10/18/24. 2. The pharmacist recommended R #16 be evaluated to decrease the dose of escitalopram. 3. The provider documented resident with good response, maintain current dose. 4. The provider documented disagree with the pharmacist recommendation. 5. The provider did not document a clinical rationale for why R #16 should not have a dose reduction. D. Record review of R #16's entire medical record, no date, revealed the provider did not document a clinical rationale for why a GDR should not be conducted for R #16 for escitalopram 20 mg. E. On 10/09/25 at 2:11 PM, during an interview, the DON confirmed the following: 1. R #16 was taking the same dose of escitalopram and oxcarbazepine since he arrived on 10/17/24. 2. The pharmacist recommended a GDR for escitalopram on 07/28/25 and the provider declined the GDR. 3. R #16's provider did not document a clinical rationale for why a GDR should not be conducted for escitalopram. F. On 10/14/25 at 12:29 PM, during an interview, the Medical Director confirmed the following: 1. A GDR for antidepressant medications should be attempted if a resident was not showing signs of depression. 2. Providers were expected to document a clinical rationale for why a GDR should not be attempted.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview, the facility failed to ensure nursing staff completed mandatory behavioral health training (a form of instruction that provides knowledge and skills to identify, understand, and respond to mental health and substance use challenges, including the promotion of well-being) for 1 (LPN #26) of 4 (LPN #17, LPN #18, LPN #25, and LPN #26) staff 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 staff training records revealed LPN #26 did not complete the mandatory behavioral health training. B. On 10/14/25 at 12:29 PM, during an interview, the Administrator stated the following: 1. He was unable to find LPN #26's behavioral health training. 2. If LPN #26 did not complete the behavioral health training, he would ensure she completed it that day. 3. All staff were required to complete behavioral health training.