STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325047	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Oro Center	1005 Lujan Hill Road Las Cruces, NM 88005

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on observation and interview, the facility failed to safeguard resident medical record information for all 126 residents (residents were identified by the census provided by the Administrator on 06/17/24). This deficient practice could likely result in the residents' information being viewed by unauthorized residents, visitors, and staff. The findings are: A. On 06/17/24 at 9:16 AM, during an observation of the 500 Unit at room [ROOM NUMBER] and 507, a computer on the medication cart was open, and the screen was not locked and staff were not present. Resident information was visible. All 126 resident's information can be accessed from this computer. B. On 06/17/24 at 9:18 PM, during an interview, CMA #11 confirmed that the computer was left open with resident information visible. CMA #11 confirmed that the computer is not supposed to be left unlocked. CMA #11 said that he just stepped away real fast because he had to take care of something.

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47510 Based on observation and interview, the facility failed to provide a comfortable and homelike environment for all 126 residents (residents were identified by the census provided by the Administrator on 06/17/24) when they failed to pick up dirty used tissue from the floor. This deficient practice could likely cause residents to feel like they are not living in a comfortable home-like environment and like they are not valued. The findings are: A. On 06/17/24 at 9:31 AM, during an observation of the facility, two wash basins with used crumpled up tissue and a used latex glove lay under a table on the floor in the activity room between the 500 and 700 Unit. The basins sat there for approximately thirty minutes. Staff were present in the area and did not pick up the tissue and a used latex glove. B. On 06/17/24 at 9:34 AM, during an interview, the Activities Coordinator confirmed there were two wash basins with used tissue and a latex glove on the floor. The Activities Coordinator said that he thinks they belonged to a resident that goes outside to smoke and will bring her things and just dump them in the activity room. The Activity Coordinator said that they should be picked up and thrown away and not just left there.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47510 Based on record review and interview the facility failed to report injuries of unknown source within two hours to the State Agency (SA) for 1 (R #11) of 1 (R #11) residents sampled for abuse. If the facility fails to report allegations of abuse or neglect to the SA within two hours, then residents could likely continue to be abused or suffer serious bodily injury. The findings are: A. On 06/17/24 at 10:52 AM, during an interview, R #11's son said he went to visit R #11 about two and a half months ago (R #11's son was unsure of the date). R #11's son said R #11 had a bruise on her forehead. R #11's son said he asked LPN #11 what had happened to R #11, and she told him that she did not know. R #11's son said he asked R #11 what happened. He stated he touched R #11's bruise, and R #11 winced at the touch. B. On 06/17/24 at 11:30 AM, during an interview, LPN #11 said she remembered R #11's family visited and asked about a bruise on R #11's forehead. LPN #11 said she assessed R #11 and did not think it was a bruise, she said it was a discoloration. LPN #11 did not feel a lump. LPN #11 said she did not document the incident, and she did not report it because she did not think it was a bruise. LPN #11 did not specify the date. C. On 06/17/24 at 11:45 AM, during an interview, LPN #11 said that R #11 complained of pain to the groin area on 06/03/24. LPN #11 said that there was no witnessed fall for R #11. D. Record review of R #11's nurse's progress note dated 06/04/24 revealed the following: 1. R #11 complained of pain to the right side of groin. 2. LPN #11 notified Nurse Practioner (NP) of R #11's pain and NP ordered x-rays. 3. Radiology reported conclusion was right hip fracture. 4. NP gave orders to send R #11 to the hospital for hip fracture. E. Record review of R #11's medical record revealed, the record did not contain any documentation that a report for injuries of unknown source was reported within two hours to the State Agency for the bruise on R #11 forehead and for R #11's right hip fracture. F. On 06/20/24 at 10:51 AM, during an interview, the Administrator said the bruise on R #11's forehead was not reported. The Administrator said she did not know about the bruise on R #11's forehead. The Administrator said the fracture of R #11's hip was not reported within 2 hours of the incident. The Administrator said that she did not report the fracture because she believed the cause of the fracture was osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes), not an unknown injury.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49313 Based on record review and interview the facility failed to ensure that residents, their representatives, and the Ombudsman received a written notice of transfer as soon as practicable for 1 (R #21) of 1 (R #21) residents reviewed for hospitalization . This deficient practice could likely result in the resident or their representative not knowing the reason or location the resident was discharged . The findings are: A. Record review for R #21's nursing progress note, dated 05/29/24, revealed the facility transferred R #21 to the hospital on 05/29/24. B. Record review of R #21's transfer notification form, dated 05/29/24, revealed the following: 1. The form had family member #2 (FM #2) on the form for the notification. 2. The section of the form that stated Copy of this notice was mailed to the resident/family, and Ombudsman on _____(date) was blank. C. Record review of R #21's nursing progress note, dated 05/30/24, revealed the facility transferred R #21 to the hospital on 05/30/24. D. Record review of R #21's transfer notification form, dated 05/30/24, revealed the following: 1. The form had FM #2's name on the form for the notification. 2. The section of the form that stated Copy of this notice was mailed to the resident/family, and Ombudsman on _____(date) was blank. E. On 06/17/24 at 11:56 AM, during an interview, R #21 family member #1 (FM #1) revealed the following: 1. The facility called her or her sister (FM #2) to notify about any change in condition for R #21. 2. They were notified by phone about R #21's transfer to the hospital on 05/29/24 and 05/30/24. 3. She did not receive written notifications for R #21's transfers to the hospital on 05/29/24 and 05/30/24. F. On 06/20/24 at 10:15 AM, during an interview with R #21's FM #2, she stated the following: 1. She did not receive written notifications for R #21's transfers to the hospital on 05/29/24 and 05/30/24. 2. She did not provide her address to the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility did not ask her for her address. G. On 06/20/24 at 10:22 AM, during an interview with the Ombudsman, she confirmed she did not receive a written copy of the transfer notices for R #21's hospital transfers on 05/29/24 and 05/30/24. H. On 06/20/24 at 9:43 AM, during an interview with Unit Manager #21, she confirmed the following: 1. She is responsible for the process for transfer notifications. 2. She receives the transfer notices from the nurses and ensures the notices are complete. 3. Once the notices are complete, she gives them to the receptionist. 4. The receptionist is responsible for mailing the transfer notices to the resident representatives and the Ombudsman. 5. R #21's transfer notification, dated 05/29/24, did not have a date staff sent the form to the resident representative and the Ombudsman. 6. R #21's transfer notification, dated 05/30/24, did not have a date staff sent the form to the resident representative and the Ombudsman. 7. She was unable to determine if staff mailed the form to the resident representative and the Ombudsman. 8. It was expected for staff to mail the transfer notices to the resident representative and the Ombudsman after every transfer from the facility.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49313 Based on record review and interview, the facility failed to ensure residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 1 (R #21) of 1 (R #21) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are: A. Record review of R #21's nursing progress note, dated 05/29/24, revealed R #21 was transferred to the hospital on 05/29/24. B. Record review of R #21's Bed Hold Policy Notice and Authorization form, dated 05/29/24, revealed the form was blank on the section for the signature of the resident or representative, which indicated they received a copy of the notice. C. Record review of R #21's nursing progress note, dated 05/30/24, revealed R #21 was transferred to the hospital on 05/30/24. D. Record review of R #21's Bed Hold Policy Notice and Authorization form, dated 05/30/24, revealed the form was blank on the section for the signature of the resident or representative, which indicated they received a copy of the notice. E. On 06/17/24 at 11:56 AM, during an interview, R #21's family member (FM) #1 stated she did not receive a written notification of the facility's bed hold policy after R #21 transferred to the hospital on 05/29/24 and on 05/30/24. F. On 06/20/24 at 10:15 AM, during an interview with R #21's FM #2, she revealed the following: 1. She did not receive a written notification of the facility's bed hold policy after R #21 transferred to the hospital on 05/29/24 and on 05/30/24. 2. She had not provided her address to the facility. 3. The facility did not ask her for her address. H. On 06/20/24 at 9:43 AM, during an interview with Unit Manager #21, she confirmed the following: 1. She is responsible for the process for bed hold notifications. 2. She receives the bed hold notifications from the nurses. 3. She gives the bed hold notifications to the Business Office Manager (BOM) to write in the number of bed hold days the resident has remaining. 4. Once the BOM completes the form, she gives it back to UM #21. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Once the bed hold notifications are complete, she gives them to the receptionist. 6. The receptionist is responsible for mailing the bed hold notifications to the resident representative. 7. R #21's bed hold notification form did not have a signature from the resident or the resident representative for R #21's transfer to the hospital on 05/29/24. 8. R #21's bed hold notification form did not have a signature from the resident or the resident representative for R #21's transfer to the hospital on 05/30/24. 9. She was unable to determine if staff mailed the form to the resident representative. 10. It was expected for staff to mail the bed hold notices to the resident representative after every transfer from the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review, and interview, the facility failed to ensure staff revised the care plan for 1 (R #1) of 3 (R #1, R #2, and R #11) residents to reflect R #1 ate independently and did not need supervision/cue/assistance with meals. This deficient practice could likely result in staff being unaware of changes in the care 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 #1's care plan, dated 01/28/24, revealed R #1 required supervision/cue/assistance with meals. B. Record review of R #1 Occupational Therapy (OT) (a form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life) Discharge Summary, dated 8/10/23, revealed the resident could eat independently. C. Record review of R #1's quarterly Minim Data Set (MDS) (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status.) assessment dated [DATE], revealed R #1 ate without assistance from a helper. D. On 06/17/24 at 2:58 PM, during an interview with the Dietician, he confirmed R #1 did not have issues with swallowing and did not require supervision, since R #1 ate independently. E. On 06/20/24 at 10:30 AM, during an interview with the MDS Assistant (MDSA) she stated the following: 1. She obtained R #1's information from net health (a healthcare technology provider offering specialized Electronic Health Record (EHR) software) and she updates the information quarterly on the MDS. 2. She confirmed she did not update the care plan since it stated R #1 needed minimal assistance with some Activities of Daily Living (ADL's) (refers to an individual's daily self-care activities with or without assistance). 50497

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50497 Based on interview, and record review, the facility failed to ensure there was a functional system in place to ensure staff could initiate / not initiate cardiopulmonary resuscitation (CPR; any medical intervention used to restore circulatory and/or respiratory function that has ceased) during an emergency for all 73 residents who were Full Code (individual wants resuscitation and all life saving measures during a medical emergency) when they failed to: 1) Check pulse and air way on R #1 2) Ensure staff knew what procedure to follow in an emergency. 3) Track staff's CPR certification to ensure the certification was up to date. Residents were identified by the resident code list provided by the Administrator on [DATE]. This deficient practice could likely cause confusion among the nursing staff who may not be aware of what to do for residents who are Full Code and those residents who were coded Do Not Resuscitate (DNR; do not perform life saving measures, allow natural death), resulting in residents not receiving the prompt initiation of CPR. The findings are: R #1 A. Record review of R #1's New Mexico Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed R #1 was Full Code. B. Record review of R #1 progress notes revealed the following: 1. A note, dated [DATE], revealed staff found R #1 unconscious in his bedroom following the evening dinner and began CPR four minutes after the LPN was notified. 2. A note, dated [DATE], revealed staff began to suction (the production of a partial vacuum by the removal of air in order to force fluid into a vacant space or procure adhesion.) R #1 six minutes after CPR was started. C. On [DATE] at 12:38 PM, during an interview with Certified Nursing Assistant (CNA) #1,she stated the following: 1. If she found a resident unconscious then she would do the following: a. Check pulse, b. Check air way, c. Start CPR, (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Call for help 2. She was the CNA who responded to R #1 during the incident on [DATE]. 3. She did not know what the code status for R #1 at that time. 4. She was CPR certified. 5. LPN #1 was notified and LPN initiated CPR on R #1. D. Record review of the facility's CPR Policy and Procedure revealed the following: 1. The center will perform CPR on all patients, except in certain limited circumstances, unless there is a written physician's order, agreed to by the patient or health care representative, not to resuscitate, in accordance with state regulation/law. 2. Licensed nursing staff must maintain current CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessment. Online-only certification is not acceptable. 3. CPR is to be provided in the location where the patient is discovered as long as the location is safe for responder and patient. If the location is not safe, patient will be moved to the nearest safe location for resuscitation. 4. To provide a process to determine when to initiate CPR and what steps to follow when providing CPR. Staff knowledge of CPR procedures. E. On [DATE] at 11:37 AM, during an interview with CNA #2, she stated she received a sheet at the beginning of shift with the residents' code status and would let the nurse know right away if there is an emergency with any resident. F. On [DATE] at 11:38 AM during an interview, CNA #4 stated the following: 1. The code status are written in the resident record at the nurses station. 2. If a resident was not responsive then they call Code Blue. Staff stay with the resident until someone comes. 3. Staff did not know if the resident was full code when going into the residents rooms. Staff tried to learn who was DNR and who was not. G. On [DATE] at 11:43 AM during an interview, CNA #5 stated the following: 1. She knew some of the residents' code status but not all of them. 2. She did not know where to find the residents' code status but would ask the nurse where it was. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. If the nurse was not available she would call the DON. 4. She was CPR certified. 5. She would probably start CPR right away but she did not know the code status. H. On [DATE] at 11:46 AM during an interview with CNA #3, she stated she asked the licensed nurses for the resident's code status and would yell for help in case of an emergency. I. On [DATE] at 11:46 AM during an interview, CNA #6 stated the following: 1. He knew the residents' code status was in the binder used for code status located at the nurse's station. 2. He was not CPR certified and would have to get a nurse to initiate CPR. J. On [DATE] at 10:45 AM, during an interview with the DON, she stated the following: 1. She expected the licensed nurses to know the residents' code status 2. CNAs should know where to find the resident's code status. 3. She also expected a CNA to initiate CPR immediately if they were CPR certified. CPR Certification Tracking K. On [DATE] at 10:58 AM, during an interview with the Administrator, she stated the following: 1. Payroll tracked the CPR certification for Nurses. 2. Payroll notified the staff when their certifications were about to expire. 3. Corporate also notifies the facility about expiring certifications. L. On [DATE] at 11:35 am, during an interview with Payroll, she stated the following: 1. She did not track CPR certifications for any staff. 2. She implemented the tracking last week (date was not provided).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47510 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #11) of 3 (R #1, R #2, and R #11) 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: A. On 06/17/24 at 10:52 AM, during an interview, R #11's son said he went to visit R #11 about two and a half months ago. R #11's son said R #11 had a bruise on her forehead. R #11's son said he asked LPN #11 what had happened to R #11, and she told him that she did not know. R #11's son said he asked R #11 what happened. He stated he touched R #11's bruise and she winced and said it hurt a little. B. On 06/17/24 at 11:30 AM, during an interview, LPN #11 said she remembered R #11's family visited and asked about a bruise on R #11's forehead. LPN #11 said she assessed R #11 and did not think it was a bruise, she did not feel a lump. LPN #11 said she believed that R #11 had a discoloration and not a bruise. LPN #11 said she did not document the incident, and she did not document the bruise on R #11's forehead or concerns R #11's family had in R #11's medical record. C. Record review of R#11's medical records, the records did not contain any documentation of R #11's bruise. D. On 06/17/24 at 11:45 AM, during an interview, the Unit Manager (UM) said she was not notified that R #11's family had a concern about a bruise on the resident's forehead. The UM stated she did not know that R #11's family had told staff that R #11 had a bruise on her forehead. The UM stated her expectation was for staff to document any bruises, concerns or changes with the resident in the resident's medical record.