

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Casa DE Oro Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Lujan Hill Road Las Cruces, NM 88005	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Past Noncompliance</p> <p>Based on record review and interview, the facility failed to ensure wound care orders were implemented, wound care was completed, and staff documented that the wound care was performed for 1 (R #1) of 3 (R #1, R #2, and R #17) residents reviewed for pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time). These deficient could likely result in the provider being unaware of the resident's current condition, leading to inconsistent interventions and worsening of pressure ulcers. The findings are:</p> <p>A. Record review of R #1's admission record (no date) revealed R #1 was admitted to the facility on [DATE].</p> <p>B. Record review of the wound care consultation (outside nurse practitioner that provides consultation to the facility for wound treatment) note dated 10/24/24 revealed the following:</p> <ol style="list-style-type: none"> 1. R #1 presented with a stage 3 pressure (fatty tissue may be visible but bone, tendon or muscle are not exposed) injury to sacrum (triangular bone at the base of the spinal column). 2. Wound care order: primary dressing wound vacuum assisted closure (Wound VAC; a therapeutic technique using a suction pump, tubing, and a dressing to remove excess exudate and promote healing in acute or chronic wounds), apply Duoderm (name brand of gel dressing that helps maintain a moist wound bed) to periwound (tissue surrounding the wound that has been affected by the wound), black foam (foam dressing used with wound vac which is connected to a pump to provide suction to help drain fluids from the wound bed and reduces swelling) to wound bed (bottom part of a wound where new skin and tissue grow as the wound heals), cover with Adaptic (name brand of specialized nonstick wound dressing designed to protect the wound bed), set suction to 125 mmHg (pressure setting for wound vac) every Tuesday, Thursday, and Saturday. C. Record review of R #1's Admission Minimum Data Set (MDS; comprehensive clinical assessment completed for all nursing home residents) dated 10/28/24 revealed the following: <ol style="list-style-type: none"> a. R #1 had one unhealed stage 3 pressure ulcer. b. R #1's stage 3 pressure ulcer was present on admission. <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. Record review of R #1's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. Facility staff did not enter the Wound Vac ordered by the wound care consultant on 10/24/24. 2. Order start date 10/30/24, order discontinue date 10/31/24: clean wound with normal saline, pat dry with 4x (times) 4 (gauze), apply Santyl (topical enzyme medication used to remove damaged or burned skin, aiding in wound care and the growth of healthy skin) to slough (layer of dead tissue that accumulates on surface of a wound and can impede healing) area, cover with Hydroblue ready (sic; Hydrofera Blue Ready; dressing that maintains a moist wound environment without the need for hydration and has a wear time of up to seven days, requiring less dressing changes). Secure with protective dressing one time a day every Monday, Wednesday, and Friday. 3. Order date 10/31/24: clean wound with normal saline, pat dry with 4x4, apply Santyl to slough area, pack (fill the open wound space with dressing material) with iodoform packing (saturated gauze fabric that is effective in promoting wound healing, managing exudate [liquid produced by the body in response to tissue damage and wound healing], and preventing infections), secure in place with border dressing (absorbent wound dressing that helps protect the wound surface and has adhesive tape to hold the dressing in place and maintain a moist wound environment) every morning. <p>E. Record review of R #1's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed) for October 2024 revealed facility staff did not document any wound care provided to R #1 from 10/23/24 through 10/29/24.</p> <p>F. Record review of R #1's Nursing Progress Notes for October 2024 revealed staff did not notify the wound care consultant that the Wound Vac did not stay on R #1 on 10/24/24, and that R #1 required other wound care orders.</p> <p>G. On 01/07/25 at 2:10 PM, during an interview, LPN #1 stated the following:</p> <ol style="list-style-type: none"> 1. He assisted the facility wound care nurse in providing wound care to R #1. 2. LPN #1 could not recall the dates or how often he assisted with wound care for R #1. 3. He recalls that the Wound Vac did not stay on R #1, LPN #1 believes this was on 10/24/24 after the wound care consultant evaluated R #1's pressure ulcer. 4. He assisted the wound care nurse with packing R #1's pressure ulcer wound when the Wound Vac did not stay on. 5. He did not document any wound care provided for the resident because the wound care nurse was responsible for documentation. 6. He did not speak to the wound care consultant regarding R #1's pressure ulcer. <p>H. On 01/08/25 at 12:54 PM, during an interview, the DON stated the following:</p> <ol style="list-style-type: none"> 1. Facility staff did not enter the wound care order provided by the wound care consultant on 10/24/24 onto the physician's orders. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. If the wound care order was not entered then staff will not be prompted to complete the wound care and will not know what care to provide.</p> <p>3. Facility staff did not document the wound care provided to R #1 from 10/23/24 through 10/29/24.</p> <p>4. The facility wound care nurse did not document any communication with the wound care consultant regarding the Wound Vac treatment not staying on R #1.</p> <p>5. She stated that her expectation is for staff to enter wound care orders on the date the order is received from the wound care consultant, staff document that the wound care is provided to the residents in their medical record, and staff document communication with the wound care consultant.</p> <p>This deficient practice was cited as past noncompliance:</p> <p>Based on facility investigation for pressure ulcers the following interventions were implemented and placed in the plan of correction prior to survey investigation and verified on the revisit completed on 12/12/2014.</p> <p>An audit of current residents with wounds was completed by 11/19/24 to ensure that orders and treatment protocols were in place, and wounds were reported to PCP (primary care provider), and interventions were identified and placed in the care plan. Additional wounds from ongoing resident assessments were documented, reported to PCP, Care planned and treatment started.</p> <p>Measures/Systemic Changes:</p> <p>DON/designee educated nurses on wound process with emphasis on reporting all new and worsened wounds to providers, ensuring appropriate interventions for wound healing and prevention were identified and in place, and documenting wound measurements at least every seven (7) days by 11/19/24.</p> <p>In daily clinical meetings, DON/designee reviewed new admissions/new wound orders/new wounds identified, nursing notes to ensure treatment orders were written and implemented, wound measurements were documented and care plans were updated per identified interventions for wound healing and prevention.</p> <p>Monitoring:</p> <p>DON/designee audited all new and worsened wounds weekly for four (4) weeks then monthly x (times) 2 months to ensure the wound process is in place.</p> <p>The facility QAPI (Quality Assurance and Performance Improvement) committee reviewed the corrective actions, staff training and audits described above to monitor the effectiveness of the plan for three months to ensure that the correction is achieved and sustained.</p>		