

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  03/03/2025
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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52223</p> <p>Based on record review and interview, the facility failed to have the physician document the required discharge information in the resident's medical records for 1 (R #26) of 1 (R #26) residents reviewed for discharges.</p> <p>This deficient practice could likely cause an unsafe discharge due to a lack of information or documentation.</p> <p>The findings are:</p> <p>A. Record review of R #26's face sheet, undated, revealed R #26 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>B. Record review of R #26's Progress Notes revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/25/25, staff documented R #26 had a change of condition. The provider ordered R #26 to be sent out for Higher acuity level of care. R #26 was transported to a local hospital.</li> <li>2. On 01/25/25, the Administrator documented she notified R #26's Power of Attorney (POA: a power of attorney is a legal authorization that gives the agent or attorney the authority to act on behalf of an individual referred to as the principal) that R #26 was being discharged immediately to the hospital. The Administrator documented R #26 harmed two residents, and the facility would not be able to accept R #26 back, due to the immediate danger R #26 posed to the residents of the facility.</li> </ol> <p>C. Record review of R #26's entire medical record, undated, revealed the Physician did not document the following:</p> <ol style="list-style-type: none"> <li>1. The facility was not able to provide R #26 needs.</li> <li>2. The attempts the facility made to meet the needs of R #26.</li> <li>3. How the transferring facility was able to meet R #26's needs.</li> </ol> <p>D. On 02/28/25 at 9:20 AM, during an interview, the Administrator confirmed she was not able to provide documentation from the physician about the following:</p> <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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. The facility was not able to provide R #26 needs.</li> <li>2. The attempts the facility made to meet the needs of R #26.</li> <li>3. How the transferring facility was able to meet R #26's needs.</li> </ol>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to revise the care plan for 3 (R #8, R #9, and R #10) of 3 (R #8, R #9, and R #10) residents reviewed for Resident/Patient/Client Neglect.</p> <p>This deficient practice could likely result in staff being unaware of changes in care to be provided and residents not receiving the care related to changes in their health status or healthcare decisions.</p> <p>The findings are:</p> <p>R #8</p> <p>A. Record review of R #8's Lift Transfer Evaluation dated 02/02/25, revealed R #8 required at least two staff to assist with lift device.</p> <p>B. Record review of R #8's Care plan dated 02/03/25 revealed R #8's need for a lift device and interventions were not documented.</p> <p>R #9</p> <p>C. Record review of R #9's Lift Transfer Evaluation dated 01/01/25, revealed R #9 required at least two staff to assist with lift device.</p> <p>D. Record review of R #9's care plan dated 02/04/25 revealed R #9's need for a lift device and interventions were not documented.</p> <p>R #10</p> <p>E. Record review of R #10's Lift Transfer Evaluation dated 01/31/25, revealed R #10 required at least two staff to assist with lift device.</p> <p>F. Record review of R #10's care plan dated 02/03/25 revealed R #10's need for a lift device and interventions were not documented.</p> <p>G. On 02/27/25 at 10:17 AM, during an interview, the DON confirmed that R #8, R #9, and R #10's care plans had not been revised to reflect that the residents required a lift device and two person assistance. The DON stated the care plans should document resident's needs and interventions. The DON stated her expectation is that the lift devices and the number of staff needed to safely utilize the lift should be care planned for the resident's needing them.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>52223</p> <p>Based on interview and record review, the facility failed to develop and implement a discharge planning process for 1 (R #26) of 1 (R #26) resident reviewed for discharge planning, when they failed to:</p> <ol style="list-style-type: none"> <li>1. Develop the R #26's individualized discharge goals and needs.</li> <li>2. Include R #26 and R #26 PoA/family in the discharge planning.</li> </ol> <p>Theses deficient practices are likely to prevent a safe transition from the facility to the resident's post-discharge setting. The findings are:</p> <p>A. Record review of R #26's face sheet, undated, indicated R #26's admission to the facility was on 03/25/23.</p> <p>B. Record review of the Notice of Transfer and discharge date d 01/25/25, revealed R #26 was discharged from the facility on 01/25/25. Staff did not document that R #26 Power of Attorney (POA: a power of attorney is a legal authorization that gives the agent or attorney the authority to act on behalf of an individual referred to as the principal) was informed of the discharge 30 days prior to discharge.</p> <p>C. Record review of R #26's entire medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. Staff did not document a discharge plan that included R #26's discharge goals and needs.</li> <li>2. Staff did not document the IDT (Interdisciplinary team) was involved in R #26's discharge.</li> <li>3. Staff did not document that R #26 POA was involved in R #26's discharge prior to notice of discharge on 01/25/25.</li> </ol> <p>D. On 02/28/25 at 10:06 AM, during an interview, the Social Worker confirmed she was not involved with R #26 discharge. The Social Worker stated, she was made aware of R #26 being discharged when she returned to work, and confirmed she did not complete a discharge note for R #26.</p> <p>E. On 02/28/25 at 9:20 AM, during an interview, the Administrator confirmed R #26's discharge goals or needs were not documented in the residents' chart. The Administrator confirmed R #26 was not given 30-day notice for discharge. The Administrator confirmed the facility held a discharge meeting for R #26 on 01/25/25, on the phone with R #26's POA. The Administrator confirmed she documented in the progress notes that R #26 was immediately discharged and that the POA was notified.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52223</p> <p>Based on record review and interview, the facility failed to ensure staff completed a discharge summary that included a recapitulation (a summary describing the resident's course of treatment while residing in the facility), and a list of all medication at the time of discharge for 1 (R #26) of 1 (R #26) residents sampled for discharge from the facility.</p> <p>This deficient practice could likely lead to the receiving facility, community agency, or family members not knowing what the current care needs and/or current medications the resident needs. The findings are:</p> <p>A. Record review of R #26's face sheet, undated, revealed R #26's was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>B. Record review of R #26's Medical Record, undated, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #26 was discharged from the facility on 01/25/25 to local hospital.</li> <li>2. Staff did not document a recapitulation of the resident's stay, medication list, or a discharge summary.</li> <li>3. Staff did not document that R #26 was provided with a discharge summary.</li> </ol> <p>C. On 02/28/25 at 9:20 AM, during an interview, the Administrator confirmed staff did not complete R #26's discharge summary at the time of discharge. The Administrator also stated the staff did not complete and sign the resident recapitulation of stay on the same day of the resident's discharge.</p> <p>D. Record review of R #26's progress note, dated 01/25/25, revealed the Administrator notified R #26's Power of Attorney (POA: a power of attorney is a legal authorization that gives the agent or attorney the authority to act on behalf of an individual referred to as the principal) that R #26 was being discharged immediately to the hospital. The Administrator documented that R #26 harmed two residents, and the facility would not be able to accept R #26 back, due to the immediate danger R #26 poses to the residents of the facility.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>47510</p> <p>Based on observation and interview, the facility failed to ensure appropriate treatment and services for Foley Catheter tubing (soft plastic or rubber tube that is inserted to the bladder to drain the urine and is connected to a collecting bag) care for 1 (R #13) of 1 (R #13) randomly observed resident.</p> <p>This deficient practice could likely result in residents getting infections.</p> <p>The findings are:</p> <p>A. On 02/26/25 at 2:26 PM, during an observation of the Activity Room on the [NAME] Unit, R #13's catheter tubing dragged on the floor while he self propelled in his wheelchair.</p> <p>B. On 02/26/25 at 1:18 PM, during an interview, LPN #8 confirmed R #8's Foley tubing was dragging on the floor and the catheter tubing should not be on the floor.</p> <p>C. On 02/26/25 at 2:26 PM, during an interview, the DON confirmed R #8's catheter tube is not supposed to be dragging on the floor. The DON said the tubing should be changed after dragging on the floor.</p> <p>D. Record review of the facility's Catheter: Indwelling Urinary Policy dated 02/01/23, revealed to secure catheter tubing keeping the drainage bag below the level of the patient's bladder and off of the floor.</p>