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	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Oro Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47510 Based on interview, the facility failed to report elopements to the State Agency (SA) for 2 (R #1 and R #3) of 3 (R #1, R #2 and R #3) residents sampled for elopement, when they failed to report to the state agency an elopement by R #1 and R #3 on 04/22/25. If the facility fails to report allegations of elopement to the SA, then residents could likely suffer serious bodily injury as a result of the elopement. The findings are: A. On 05/08/25 at 3:00 PM, during an interview, Maintenance Assistant #2 said that on 04/22/25 at approximately 6:30 PM, he saw R #1 and R #3 in the the facility's south parking lot area. C. On 05/08/25 at 3:17 PM, during an interview, R #3 said that he and R #1 went out of the back gate one day. R #3 said that R #1 wanted him to leave with her. R #3 said that staff came out and got them and took them back into the facility (R #3 was not specific about which staff). D. On 05/08/25 at 3:38 PM, during an interview, the Administrator said that she did know that R #1 and R #3 were found out by the dumpsters south of the facility. The Administrator said that she did not consider it an elopement because R #1 and R #3 were still on the facility grounds. The Administrator said that she did not report the elopement to the SA.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review and interview, the facility failed to keep residents free from accidents for 3 (R #1, R #2, and R #3) of 3 (R #1, R #2, and R #3) residents sampled for elopement when staff failed to do the following: 1. Recognize the elopement risk for R #1 and R #3. 2. Secure the exit doors and the exterior gates of the facility before and after R #1, R #2 and R #3 eloped on 04/20/25 and 04/22/25. These deficient practices resulted in multiple elopements/attempted elopements: 1. R #2 eloped on 04/20/25, 2. R #3 eloped on 04/22/25 with R #1, 3. R #1 eloped on 04/22/25 with R #3, attempted to elope on morning of 04/24/25, and eloped on afternoon of 04/24/25 which resulted in R #1 being missing for approximately 30 hours and being hospitalized for four days in the Intensive Care Unit for emergency dialysis, dehydration, and sunburn as a result of the elopement on 04/24/25 through 04/25/24. The findings are: R #2 elopement on 04/20/25 A. Record review of R #2's medical record revealed R #2 had the following diagnoses: 1. Dementia (impairment of at least two brain functions, such as memory loss and judgment), and 2. Muscle weakness. B. Record review of the facility's incident report dated 04/21/25, revealed that R #2 eloped from the facility on 04/20/25 at 11:30 AM. R #2 was found located outside the facility in the south parking lot area (on 04/20/25). The incident report stated that R #2 left through a dining room door. The lock on the dining room door was not functioning properly. C. Record review of R #2's elopement evaluation dated 04/09/25, revealed Score value of 1 or higher indicates a Risk of Elopement. R #2 scored the following on her elopement evaluation: 1. R #2 had a history of elopement or attempts to leave the facility. 2. R #2 verbally expressed the desire to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. R #2 wandering behavior was a pattern and goal directed (i.e. specific destination in mind, going home etc.). 4. R #2 wandering behavior is likely to affect the safety or well-being of self /others. 5. R #2 Resident's wandering behavior likely to affect the privacy of others. 6. Staff did not document focus, goals, or interventions check boxes. 7. Staff did not document Clinical suggestions check boxes. D. On 05/09/25 at 12:31 PM, during an interview, CNA #1 stated that R #2 always told him she wanted to go home. CNA #1 stated that R #2 would wait for the front door to open, and R #2 would try to get out. CNA #1 stated that R #2 would also follow people out of the front door if they weren't paying attention. CNA #1 stated that even the Administrator had to direct R #2 back into the facility after R #2 had walked out the door following someone. (CNA #1 was not specific about a date) E. On 05/09/25 at 12:35 PM, during an interview with LPN #1, she stated that staff knew R #2 was an elopement risk. LPN #1 stated that she would be sitting at the nurse's station, and she would see R #2 with her walker heading down the hall towards the door anytime it was opened. LPN #1 stated that they were always reminding people to look out for R #2 when leaving the facility. F. On 05/08/25 at 3:38 PM, during an interview, the Administrator stated that after R #2 was found in the south parking lot area, the Administrator told maintenance to check the doors and gates. The Administrator stated that after R #2 was found in the south parking area, she went out there and determined it to be unsafe for the residents to be out in that area and told staff to lock the gate leading out to that area. G. Record review of a text message dated 04/20/25, revealed the Administrator had sent a text message to the Maintenance Director (MD), telling him that the doors on the [NAME] side into the parking lot were not locking and the gate in the back courtyard was being left unsecured and open, and that it must be secured. H. On 05/08/25 at 3:06 PM, during an interview, MD stated that the south courtyard gate was never locked. MD #1 stated that there was a padlock on the gate, but it was never secured in the locked position. MD #1 stated he would unlock the gate in the morning, and secure the lock, in the locked position at night. MD stated that he secured the gate after instructed to do it by the Administrator. Findings related to elopement on 04/22/25: I. Record review of R #1's medical record revealed R #1 had the following diagnoses: 1. End stage renal failure (kidneys no longer work properly) requiring dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), 2. Type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), and 4. Cognitive communication deficiency (attention and concentration difficulties). J. Record review of R #3's medical record revealed R #3 had the following diagnoses: 1. Dementia, 2. Mild cognitive impairment (condition in which people have more memory or thinking problems than other people their age), 3. Muscle weakness, 4. Post Traumatic Stress Disorder (a mental health condition that's caused by an extremely stressful or terrifying event), and 5. Schizophenia (a disorder that affects a person's ability to think, feel, and behave clearly). K. On 05/08/25 at 3:00 PM, during an interview, Maintenance Assistant (MA) #2 stated that on 04/22/25 at 6:30 PM, he found R #1 and R #3 in the facility's south parking lot area. MA #2 stated that he told Unit Manager (UM) #1 about R #1 and R #3. MA #2 stated that he checked all the doors and gates and that everything was locked except for the south courtyard gate after he found R #1 and R #3. L. On 05/08/25 at 3:12 PM, during an interview, CNA #2 stated that on 04/23/25, during morning report, staff were told that R #1 and R #3 were found on 04/22/25 in the facility's south parking lot. M. On 05/08/25 at 3:17 PM, during an interview, R #3 stated that he and R #1 went out of the back gate one day. R #3 stated that R #1 wanted him to leave with her. R #3 stated that staff came out and got them and took them back into the facility. N. On 05/12/25 at 10:30 AM, during an interview, MA #2 stated that R #1 and R #3 left through the south court yard entered the physical therapy area and out the door (this contradicts MA #2's previous statement Finding K). He found R #1 and R #3 in the south parking lot. O. Record review of R #1's medical record revealed staff did not document an updated elopement assessment after R #1 eloped on 04/22/25. P. Record review of R #1's elopement evaluations revealed Score value of 1 or higher indicates Risk of Elopement. R #1 scored the following on her elopement evaluations: 1. On 10/22/24, staff scored R #1 as resident expressed the desire to go home. 2. On 01/26/25, staff scored R #1 as resident has a history of elopement or attempt of leaving the facility. Q. Record review of R #3's elopement evaluation revealed Score value of 1 or higher indicates Risk of Elopement. R #3 scored the following on her elopement evaluation: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On 05/04/25, staff documented that R #3 was not an elopement risk. 2. On 05/09/25, staff documented that R #3 wanders. a. Staff did not document that R #3 had eloped on 04/22/25. R. On 05/08/25 at 3:38 PM, during an interview, the Administrator stated she was aware that R #1 and R #3 were found out by the dumpsters in the facility's south parking lot on 04/22/25. The Administrator stated that R #1 and R #3 got out through the back gate through the corridor. The Administrator stated that R #1 and R #3 were escorted back into the facility by staff. The Administrator stated she did not know if an elopement assessments were done for R #1 and R #3 after that incident. Findings related to elopement on 04/24/25: S. On 05/08/25 at 2:31 PM, during an interview, MA #1 stated that on 04/24/25, earlier in the morning, R #1 walked out of the facility's south courtyard gate that was unlocked. MA #1 stated that he escorted R #1 back into the gated area when he found her. MA #1 stated that he immediately told the staff on the east unit that R #1 had gone out of the gate. T. Record review of the facility's incident report dated 04/24/25, revealed R #1 eloped from the facility on 04/24/25 at 12:30 PM. R #1 was not found until 04/25/25 at 6:30 PM (The facility's incident report did not detail where R #1 was found or in what condition). U. On 05/07/25 at 11:06 during an interview, R #1 stated that on 04/24/25, she walked out the South courtyard back gate (that was unsecured) of the facility because she didn't want to be there anymore. R #1 stated that she was going back to the facility she was at before. R #1 couldn't remember the name of the facility. R #1 stated that she was out of the facility over night. R #1 stated that she didn't know where to go, so she stayed in the ditch until someone found her (R #1 did not indicate how she got in the ditch). R #1 confirmed that she was unable to get herself out of the ditch. V. On 05/07/25 at 11:26 PM, during an interview, CMA #3 stated that he noticed R #1 was missing when he did med pass at 12:00 PM. CMA #3 stated that when he could not find R #1, that he and staff walked around the facility (on 04/24/25, CMA #3 was not specific about the time). CMA #1 stated that after a search of the facility that everyone was alerted that R #1 was missing from the facility. W. On 05/07/205 at 11:31 AM, during an interview, CNA #1 stated that she had noticed during lunch that R #1 was not in the dining room (on 04/24/25. R #1 was not specific about the time). CNA #1 took R #1's meal to her room. CNA #1 stated that when she went to go pick up the tray, she noticed R #1 did not eat. CNA #1 stated that she went back to the nurses station to inform the nurse about R #1, she learned that no one had seen R #1. CNA #1 stated that is when she and other staff began to look for R #1. CNA #1 stated they searched the facility and the facility grounds. X. On 05/07/25 at 11:51 AM, during an interview, the Business Office Manager (BOM) stated the following: 1. R #1 went missing around 1:00 PM on 04/24/25. 2. The facility alerted all staff that R #1 was missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Staff began walking around the facility and the BOM and Administrator got in their cars and drove the surrounding area to search for R #1 (the BOM was not specific about the time). 4. Law enforcement (LE) was called around 1:30 PM. 5. LE searched with [NAME] and did not locate the resident on 04/24/25. 6. LE left for the evening. 7. On the morning of 04/25/25, LE came back to the facility and continued their investigation. 8. Search and Rescue was called to help search for R #1 at approximately 5:00 PM (on 04/25/25). 9. R #1 was found in a ditch at 6:00 PM (approximately 30 hours missing). 10. R #1 was transferred to the hospital. Y. On 05/08/25 at 3:38 PM, during an interview, the Administrator confirmed that R #1 had dialysis scheduled on Mondays, Wednesdays, and Fridays. R #1 had missed her dialysis treatment on Wednesday, 04/23/25 because R #1's transportation did not show up to take her that day. The Administrator also confirmed that because R #1 was still missing on Friday, 04/25/25 and R #1 had missed dialysis that day as well (a total of 2 days). Z. Record review of R #1's medical record, no date revealed R #1 was in the hospital from 04/24/25 through 04/29/25. R #1 was treated for emergency dialysis, dehydration, and sunburned as a result of the elopement. The above findings resulted in an Immediate Jeopardy. The Administrator was notified on 05/09/25 at 11:00 AM. The facility submitted a final plan of removal on 05/09/25 at 5:00 PM. Plan of Removal 5/9/2025 . Identification/Correction All residents have the potential to be affected by this alleged deficient practice . .- A house wide audit of current resident assessments for elopement, was conducted by the nursing team. The Facility IDT (Interdisciplinary team) Team reviewed and identified all residents at risk for elopement, their need for increased supervision as applicable, vigilance in observation for residents at risk making or attempting to elope (including sounding door alarms, and understanding to respond immediately to assess situation and complete a new development risk assessment when that occurs. Orders and care plans reviewed for accuracy to ensure the residents identified at risk have a plan for safety, and complete daily reviews of residents at risk during clinical meetings (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- House wide head to toe assessments completed 4/30/2025. Any CIC (change in condition) noted or observed a change in condition assessment was completed with provider notification and follow up. - The facility will monitor for CIC fs, all new residents and elopement attempts during clinical meetings to ensure all risks are assessed and appropriate action taken by the facility to ensure resident safety. Orders and care plans will be updated as appropriate. - Facility inspection of exterior doors and gates completed on 4/24/25 and daily thereafter to prevent unauthorized exit. All exterior doors and gates are inspected daily to ensure they remain secure, and gates around the perimeter of property are secured at all times. Magnetic locks were installed to secure all gates automatically once closed. Daily audits by maintenance staff of all doors and gates are being completed and documented as part of the ongoing regular daily maintenance and safety checks of the facility. - The NHA and Maintenance inspected the facility environment immediately, and identified additional areas of risk for elopement including smoking areas, and immediately moved the smoking area to a secure area. - Current residents picture updated and process will implemented to ensure all new admissions have a picture on admission - Market resource clinician re-educated Administrator / Incident commander on 5/9/2025 on the elopement process and procedure searching of grounds, notifying law enforcement and any state agencies, where applicable. Center may also, if appropriate, notify local hospitals, public transportation providers, etc. Provide law enforcement and other search party members a copy of elopement risk identification form. If indicated, center staff will expand search beyond the center and grounds into the extended community. Physical search will not stop until the center is notified or instructed by law enforcement or the resident is found. Systematic Measures - Nursing staff educated on elopement assessment and process: How to identify resident elopement risk upon admission and quarterly. - When and how often to complete and elopement assessment - How to identify level of elopement risk, then care plan elopement risk - What to do when a resident is exit seeking - Reporting to nursing management immediately when a resident is exit seeking for increased assessment and observation - Reporting to management immediately when a resident is missing, exit seeking. - Options for residents who are exit seeking - Educated staff on company Elopement Policy and Procedure (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Documentation to be completed after the elopement . CIC . --New elopement assessment . update to care plan - All staff educated on monitoring exit doors upon leaving/entering and waiting 20 seconds at the door to ensure the alarm is rearmed. - All staff educated on all shifts on elopement policy and process as well as changes to be alerted to in residents such as mentation, grief, increased independence etc. - Elopement Binder updated with current residents identified at risk. Completed on 4/25/2025, and ongoing for all new residents or residents with CIC at risk. - Nurse Practice Educator/Designee began education on 4/25/2025 and continued until all staff were educated prior to their next shift. Any staff member on leave of absence (FMLA), vacation, or PRN staff will be re-educated prior to returning to duty. - Daily rounding by NHA/Designee to include locks in place and functional. - Daily change in condition audit to include review of progress notes, vitals and behaviors that put residents at risk during morning clinical meetings. Quality Assurance and Monitoring The Director of Nursing/designee will audit all new admissions and 5 current residents weekly to ensure that elopement assessments are accurate and care planned accordingly for 2 months. The NHA/designee will audit locks daily for 4 weeks and then monthly for 2 months or until ongoing compliance is achieved. QAPI (Quality Assurance and Performance Improvement) Committee Review monthly to verify ongoing compliance. DON and/or designee will bring results of audits to QAPI committee for further recommendations based on tracking and trending presented monthly for the next 2 months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator . Implementation of the POR was verified onsite. The IJ was lifted on 05/12/25 at 4:44 PM by observations, interviews, and record review. Scope and Severity was reduced to Level 2, E. Implementation was verified through: Observations of the south court yard gates to ensure the gates were closed and secure with electronic locks. Record review of the monitoring of doors, exits, and gates to ensure the doors were secured from 04/24/25 through 05/12/25. Record review of the facility's elopement evaluations audits completed on 05/12/25 to ensure all resident had an accurate and up to date elopement evaluation. R #7 was identified as an elopement risk on 05/12/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the residents' care plan and orders for all current residents at risk for elopement were in place. Record review of the house wide head to toe assessments for all residents with CIC dated 04/30/25. Record review of the facility daily clinical meeting notes for facility review of CIC, all new residents, and elopement attempts from 05/05/25 through 05/09/25. Record review of staff elopement training agenda and signature sheets for the education provided to the licensed staff, that included the following: -Elopement assessment and process -When and how often to complete and elopement assessment - How to identify level of elopement risk, then care plan elopement risk - What to do when a resident is exit seeking - Reporting to nursing management immediately when a resident is exit seeking for increased assessment and observation - Reporting to management immediately when a resident is missing, exit seeking. - Options for residents who are exit seeking - Educated staff on company Elopement Policy and Procedure - Documentation to be completed after the elopement . CIC . --New elopement assessment . update to care plan - All staff educated on monitoring exit doors upon leaving/entering and waiting 20 seconds at the door to ensure the alarm is rearmed. Interviews of five nurses (RN #8, RN #9, RN #10, LPN #8, and LPN #9) verified the in-service they received on 04/25/25 and 05/09/25 included the following: -Elopement assessment and process -When and how often to complete and elopement assessment - How to identify level of elopement risk, then care plan elopement risk - What to do when a resident is exit seeking - Reporting to nursing management immediately when a resident is exit seeking for increased assessment and observation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Reporting to management immediately when a resident is missing, exit seeking. - Options for residents who are exit seeking - Educated staff on company Elopement Policy and Procedure - Documentation to be completed after the elopement . CIC . --New elopement assessment . update to care plan - All staff educated on monitoring exit doors upon leaving/entering and waiting 20 seconds at the door to ensure the alarm is rearmed. Interview with the Unit Managers, Administrator and Nursing staff confirm that the the facility has updated the elopement risk binders that are kept on every unit nursing station with current residents identified as elopement risk on 05/12/25. Current Resident pictures were updated in the binders. Record review of the facility elopement risk binders for updated elopement risk residents with pictures.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34303 Based on observation, interview, record review the facility failed to secure medications in a medication cart and a treatment cart for all 37 residents on the 500 unit (residents were identified by the census list provided by the Administrator on 05/07/25). This deficient practice could result in residents obtaining medication not prescribed to them resulting in adverse side effects. The findings are: A. On 05/12/25 at 3:32 PM, during an observation of the 500 unit revealed the medication cart unlocked. Lancets (to prick their fingers for blood sugar level checks. These devices consist of two parts: a lancet holder that looks like a small pen; and a lancet, which is the sharp point or needle that is placed in the holder.) were in a tray on top of the medication cart. B. On 05/12/25 at 3:34 PM, during an interview RN #3 confirmed that the medication cart was unlocked. C. On 05/12/25 at 3:40 PM, during an observation of the 500 unit revealed the treatment cart unlocked. D. On 05/12/25 at 3:41 PM, during an interview RN #3 confirmed that the treatment cart was unlocked. E. On 05/12/25 at 3:44 PM, during an interview Unit Manager #4 confirmed that treatment carts and medications carts should be secured when staff are not present. UM #4 also confirmed that lancets should not be stored on top of the medication carts. F. Record review of the facility's Medication Storage Policy dated January 2025 revealed In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts . G. Record review of the facility's Treatments policy dated 07/01/24 revealed Maintain security of treatment carts and keys at all times .