

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/09/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #16 and R #17) of 3 (R #16, R #17, and R #18) residents reviewed for Percutaneous Endoscopic Gastrostomy tube (PEG, a flexible feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications directly) when staff failed to document flushing R #16 and R #17's PEG tubes. This deficient practice could likely cause staff to not have the most accurate resident information and adversely impact the care staff provides. The findings are: R #16 A. Record review of R #16's Face Sheet, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Gastrostomy status (having a surgically created opening in the stomach (a PEG-tube). b. Dysphagia, oropharyngeal phase (a swallowing disorder where food or liquid cannot easily move from the mouth into the throat and esophagus). B. Record review of R #16's physician's order revealed the following: 1. An order dated 04/22/26 and discontinued on 05/18/26, for gabapentin (medication used to treat nerve pain and prevent seizures) 18 mL (900 mg) via PEG tube three times a day. 2. An order dated 04/23/26 and discontinued on 05/18/26, for melatonin (a hormone produced naturally by your brain's pineal gland in response to darkness) 5 mg via PEG tube at bedtime. 3. An order dated 04/23/26 and discontinued on 05/18/26, for olanzapine (an atypical antipsychotic medication primarily used to treat schizophrenia and bipolar I disorder) 2.5 mg via PEG tube twice a day. 4. Staff did not document orders for monitoring or flushing (pushing water through a tube to prevent blockage) R #16's PEG tube. C. Record review of R #16's Administration Record, dated May 2026, revealed staff did not document flushing R #16's PEG tube. D. Record review of R #16's Administration Record, dated June 2026, revealed staff did not document flushing R #16's PEG tube. E. On 06/08/26 at 11:58 AM, during an interview, RN #16 stated the following: 1. R #16 has not received feedings through her PEG tube since she arrived on 04/22/26. 2. R #16 had orders to receive medications through her PEG tube that were discontinued on 05/18/26. 3. R #16 received all her medications by mouth after 05/18/26. 4. After R #16's orders for medications to be administered through her PEG tube were discontinued, she flushes R #16's PEG tube twice a day to prevent blockage. 5. She confirmed she did not document in R #16's medical record that she flushed her PEG tube. R #17 F. Record review R #17's Face Sheet, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 had the following diagnoses: a. Malabsorption due to intolerance, not elsewhere classified (a digestive diagnosis for when the small intestine fails to properly absorb specific nutrients-like fats, carbohydrates, proteins, or starches-due to an adverse food reaction that is not classified elsewhere). b. Gastrostomy status. c. Dysphagia. G. Record review of R #17's physician's orders revealed the following: 1. An order dated 04/21/26 and discontinued 05/18/26, for 150 mL hydration flushes through PEG tube every 6 hours. 2. An order dated 04/21/26 and discontinued 05/18/26, for Jevity (specialized medical nutritional formulas developed by [NAME] Nutrition, primarily used for tube feeding) at 75 milliliters per hour (mL/hr) for 12 hours. 3. An order dated 01/16/26 and discontinued 05/19/26, for flush PEG tube with 30 mL of water before and after each medication pass and between each medication. 4. All (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications for PEG tube administration were discontinued as of 05/19/26 and new orders were entered to be administered by mouth. 5. An order dated 04/29/26 for a regular textured diet with thin liquid consistency. 6. Staff did not document an order to flush R #17's PEG tube after her medications and diet were changed to by mouth on 05/18/26 and 05/19/26. H. Record review of R #17's Administration Record, dated May 2026, revealed staff did not document flushing R #17's PEG tube after 05/18/26. I. Record review of R #17's Administration Record, dated June 2026, revealed staff did not document flushing R #17's PEG tube. J. On 06/08/26 at 2:45 PM, during an interview, RN #17 stated the following: 1. R #17 has not received feedings through her PEG tube since her feedings were discontinued on 05/18/26. 2. R #17 had orders to receive medications through her PEG tube that were discontinued on 05/19/26. 3. R #17 received all her food and medications by mouth after 05/18/26. 4. She flushed R #17's PEG every day to prevent blockage. 5. She confirmed she did not document in R #17's medical record that she flushed her PEG tube. K. On 06/09/26 at 10:12 AM, during a joint interview, the DON and NP #16 confirmed the following: 1. Staff were expected to flush residents PEG tubes at least daily if not receiving nutrition and medications through the PEG tube. 2. Residents should have orders to flush the PEG tube at least daily to prevent blockage. 3. Staff were expected to document PEG tube flushes in the medical record. 4. R #16 and R #17 did not have orders in their medical record to flush their PEG tubes. 5. Staff did not document flushing R #16 or R #17's PEG tubes.		