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	10/28/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to update the medical record for 1 (R #20) of 6 (R #12, R #13, R #20, R #23, R #60, and R #66) residents reviewed for advanced directives when they failed to update the resident's code status. This deficient practice is likely to result in residents not having their wishes honored if a life threatening event occurred. The findings are: A. Record review of R #20's physicians orders, dated [DATE], revealed an order for R #20's code status to be do not resuscitate (DNR, an order that informs healthcare staff not to perform cardiopulmonary resuscitation (CPR) if a person's heart stops beating or their breathing stops). B. Record review of R #20's Medical Orders for Scope of Treatment (MOST; an advanced directive), dated [DATE], indicated the resident's advanced directive was do not resuscitate (DNR). C. Record review of the R #20's care plan, dated [DATE], indicated the resident's advanced directive was DNR. D. Record review of R #20's care plan meeting progress note, dated [DATE], revealed R #20 requested for his code status to be changed from DNR to full code. E. On [DATE] at 10:40 AM, during an interview with R #20, he confirmed that he wanted his code status to be full code (lets the health care team know that cardiopulmonary resuscitation (CPR) can be used during care). F. On [DATE] at 10:51 AM, during a joint interview with the Social Services Director and the Social Services Assistant, they stated the following: 1. Code status was discussed during resident care plan meetings. 2. If a resident wanted to change their code status, then staff should complete a MOST form and have the resident and the provider sign it. 3. Staff should enter a new order to reflect the resident's code status change. 4. Staff should update the care plan to reflect the resident's code status change. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. R #20's MOST form, care plan, and orders indicated R #20's code status was DNR. 6. R #20 requested for his code status to be changed to full code during the care plan meeting on [DATE]. 7. Staff should have completed a new MOST form for R #20 and updated R #20's orders and care plan to reflect that R #20's code status was full code.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 6 (R #4, R #31, R #36, R #45, R #46, and R #110) of 8 (R #4, R #31, R #36, R #45, R #46, R #64, R #109, and R #110) residents sampled for environment, when they failed to: 1. Repaint and match the existing paint from scuff marks and damage on the walls and doors. 2. Keep air/heat vents clean and uncovered with plastic. 3. Keep resident's commode in safe working condition. 4. Keep crash carts (a wheeled container carrying medicine and equipment for use in emergency resuscitations) free of bugs. These deficient practices 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: R # 4 A. On 09/17/24 at 2:25 PM, during an observation of R #4's room, revealed the blinds on the window were broken and in disrepair. Slats were broken and bent, and the blinds could not be lifted or lowered. The blinds were stuck. B. On 09/27/24 at 9:35 AM, during an interview, the Maintenance Director confirmed R #4's blinds were broken and not working. R #31 C. On 09/16/24 at 2:55 PM, during an observation of R #31's room revealed scuff marks on all the walls and a different color of paint was under the scuff mark. The wall behind the head of R #31's bed was a 4' (foot) x (by) 4' area that looked like something had been repaired and the repair areas was not painted to match the main color of the room. D. On 09/27/24 at 9:33 AM, during an interview, the Maintenance Director confirmed the paint on R #31's walls were scuffed, and he further confirmed the area behind the head of R #31's bed was not painted. R #36 E. On 09/17/24 at 2:45 PM, during an observation of R #36's restroom and interview, the vent was covered with plastic, aluminum foil and duct tape and the plastic and aluminum foil was halfway falling off. R #36 stated it gets cold in the restroom and the vent has been covered for one year. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 09/20/24 at 12:54 PM, during an interview with the administrator, she confirmed there was plastic, aluminum foil, and duct tape on R #36's restroom vent and the plastic and aluminum foil was halfway falling off. The administrator said that the residents get cold so they covered the vents. R #45 G. On 09/16/24 at 2:40 PM, during an observation of R #41's bathroom the toilet was turned at an angle, which made it harder to sit on the toilet. The window was covered with plastic. H. On 09/27/24 at 9:37 AM, during an interview, the Maintenance Director confirmed R #41's toilet was at an angle and was not sitting straight. The Maintenance Director confirmed the plastic over the bathroom window and said it was because it gets cold. R #46 I. On 09/18/24 at 9:17 AM, during an observation of R #46's bedroom, the air vent above R #46 head was full of lent and dust. J. On 09/18/24 at 9:17 AM, during an interview with R #46, he stated the air vent above was full of lent and dust and lent falls on his face. R #110 K. On 09/16/24 at 3:17 PM, an observation of R #110's room. the vent was covered with plastic and duct taped to the vent. The duct tape was coming off and the plastic was torn and tattered. L. On 09/16/24 at 3:19 PM, during an interview, CNA #8 confirmed that there was plastic over the vent and that the tape was coming off in R 110's room. M. On 09/30/24 at 11:02 AM, during an observation of the Dementia unit crash cart, the crash cart had black dead bugs. N. On 09/30/24 at 11:03 AM, during an interview with LPN #24, she stated confirmed there were black dead bugs on the crash cart. 50497

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on interview and record review, the facility failed to keep residents free from abuse for 3 (R #12, R #94, R #117) of 3 (R #12, R #94, and R #117) residents sampled for abuse when staff failed to: 1. Prevent staff from being verbally abusive to R #12. 2. Prevent R #94 from being physically abused, which caused injuries to R #94 face, neck, and hands. 3. Prevent R #117 from being fearful of staff who provide care. These deficient practices likely resulted in physical harm to the residents and psychosocial distress (unpleasant emotions associated with a highly stressful situation). The findings are: R #12 A. On 09/17/24 at 10:55 AM, during an interview with R #12, the following was stated: 1. About five weeks before the interview, she had fallen twice in the restroom. 2. R #12 fell because CNA #16 told her she was lazy and can do more, so R #12 went to the restroom by herself. 3. R #12 does not want CNA #16 to help her. B. Record review of Abuse Questionnaire (questions the facility staff use to ask residents to determine if they have been abused), dated 08/09/24, revealed R #12's sister told staff that [Name of CNA #16] speaks loudly not because resident is hard of hearing, but it's her tone, it's bossy, not right. C. Record review of Abuse Questionnaire, dated 08/09/24, revealed that R #66 (R #12's roommate) told staff that she does not like CNA #16 because she is mean and doesn't talk nice to R #12. D. Record review of the Complaint Narrative Investigation Follow-Up Report (5-day), dated 08/21/24, revealed the following: 1. The facility investigation determined that CNA #16 told R #12 that she was lazy because the resident stated she could not stand. 2. CNA #16 was attempting to encourage the resident to do as much for herself as possible. 3. CNA #16 has a direct, loud approach which seems bossy to the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. The facility substantiated that there was verbal abuse by CNA #16. E. On 09/25/24 at 3:32 PM, during an interview with CNA #17, the following was revealed: 1. R #12 is not supposed to transfer by herself. 2. R #12 is selective about which CNAs she will allow to help her. 3. R #12 does not like CNA #16 helping her. 4. R #12 has told him that CNA #16 had called her lazy (was unsure of date). 5. R #12 is more likely to get up without assistance when CNA #16 is working because she doesn't want CNA #16's help. 6. Several residents have told him that CNA #16 is mean to them and they don't like her. 7. A couple of months prior to the interview (he was unsure of the date) he told RN #16 and another LPN who no longer worked at the facility about CNA #16 calling the residents lazy 8. He was unsure what was done after he reported the allegations to the nurses. F. On 09/25/24 at 3:49 PM, during an interview with RN #16, the following was stated: 1. On 08/13/24, R #12 told her CNA #16 had told her she was lazy and needed to do things for herself. 2. On 08/13/24, RN #16 reported to the DON or ADON what R #12 said of CNA #16 telling R #12 she was lazy. 3. Administration made sure that CNA #16 does not work with R #12 anymore. 4. She had not been notified about any other incidents of CNA #16 telling residents that they were lazy prior to the report by R #12 on 08/13/24 5. She was not aware of any other residents who have had issues with CNA #16. G. On 09/26/24 at 1:24 PM, during an interview with R #66 (R #12's roommate), she stated CNA #16 is rude and she heard CNA #16 call R #12 lazy (resident was unsure of the dates). H. On 09/26/24 at 4:14 PM, during an interview with the DON, the following was confirmed: 1. Staff calling a resident lazy would be considered abuse. 2. She became aware of CNA #16 calling R #12 lazy after speaking with R #12's sister and after R #12 fell on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Prior to speaking with R #12's sister on 08/13/24, she had not been made aware of CNA #16 being rude or calling residents lazy 4. After the complaint from R #12's sister, she completed a training with CNA #16 on what verbal abuse looks like and being more approachable. I. On 09/30/24 at 10:57 AM, during an interview with the Administrator, the following was stated: 1. She completed the abuse questionnaires from R #12's sister. 2. She complete the abuse questionnaires from R #66 on 08/09/24 (prior to the complaint from R #12's sister on 08/13/24). 2. She became aware of CNA #16 calling R #12 lazy after R #12's sister called her to report it on 08/13/24. 3. She was not aware of any concerns about CNA #16 prior to the complaint made by R #12's sister on 08/13/24. R #117 J. Record review of R #117 admission record revealed the following: 1. R #117 was admitted to the facility on [DATE]. 2. R #117 was diagnosed with unspecified psychosis not due to a substance or known physiological condition and other specified disorders of brain. K. On 09/19/24 at 2:56 PM, during an interview with CNA #24, he stated the following: 1. On 09/11/24 at 10 PM, he was walking out the Dementia unit and noticed RN #24 yelling at R #117 in an aggressive tone being confrontational and disrespectful. 2. CNA #24 saw RN #24 dragged R #117 off the dining room chair and yelled at her, told her You can't sleep here; you need to go to your room. 3. He reported the incident to the unit manager on 09/12/24. L. On 09/20/24 at 9:52 AM, during an interview with R #117, she stated the following: 1. On multiple occasions RN #24 has hit me on my face, body, and nobody said anything because of repercussions (an unintended consequence occurring some time after an event or action, especially an unwelcome one). 2. She feels that RN #24 degraded her by telling her she had no value, and she was useless. R #117 did not provide detail of how many times this has happened. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. She was asleep on the dining room chair and RN #24 pulled her up and told her You will not be falling asleep here and sat her back down. R #117 did not provide further information. M. Record review of the facility's Abuse Questionnaire to the residents completed by facility staff on 09/24/24 revealed R #117 stated I have a threat from staff, she has not worked a shift with me, it's been addressed, this woman is dangerous [referring to RN #24]. N. On 09/24/24 at 8:34 AM, during an interview with the unit manager, she stated staff did not report the incident with R #117 and she did not know anything about the incident. O. On 09/24/24 at 2:38 PM, during an interview with CNA #24, he stated the following: 1. He reported the incident between R #117 and RN #24 to the unit manager during his shift on 09/12/24 at 2 PM. 2. He was told by the unit manager to complete a written statement, he completed the statement, and turned it in to the unit manager on 09/12/24 around 2:30 PM. 3. On 09/12/24 during his 2 PM shift, R #117 told him Last night she (RN #24) dragged me off the chair. R #117 was having behaviors and would not allow staff to provide care telling them I don't trust you all on 09/12/24. R #94 P. Record review of R #94's admission record revealed the following: 1. R #94 was admitted to the facility on [DATE]. 2. R #94 was diagnosed with unspecified Dementia (diagnosis given a person has dementia but it can't be classified as a specific type) unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Q. Record review of R #94's nursing progress notes revealed the following: 1. On 9/12/2024 at 6:36 AM, note written by RN #24 stated [Name of R #94] became very agitated while being changed, hitting, scratching, kicking, and trying to bite staff, very combative and yelling that we were trying to kill her. She had pulled off her nasal cannula and became more combative while staff put it back in place thrashing her head back and forth and screaming. She sustained skin tears to both hands and one on her left wrist. Skin tears cleaned and dressed with her resisting care and trying to tear the dressings back off. 2. According to nurse's progress note written by RN #24 revealed no other staff was present at time of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. On 09/12/24 at 1:11 PM, note written by LPN #24 stated, during morning report, night nurse reported [Name of R #94] was being combative during brief change and [Name of R #94] had obtained skin tears to bilateral (both) hands and left wrist. [Name of R #94] was medicated with as needed medications for pain and anxiety by night nurse. [Name of R #94] slept through breakfast. CNA went to get [Name of R #94] up for lunch and noted large bruise to right side of face and reported to nurse. [Name of R #94] was assessed for further injuries and noted to bruises to right calf. Skin tears cleansed and wrapped and covered with gauze. Medicated [Name of R #94] with morphine as needed. Called Power of Attorney (POA) and notified of change in condition, called Hospice twice and no response. Notified physician about change in condition. 4. Staff did not document any other progress notes in the previous months of R #94 being combative with any staff except for RN #24 on 09/12/24 during brief change. R. On 09/19/24 at 12:42 PM, during an interview with R #94's Power of Attorney (POA) she stated the following: 1. Family Member (FM) was informed by LPN #24, that R #94 was hitting and biting. 2. R #94 obtained some small cuts on her hands. 3. R #94 obtained a small bruise on her cheek. S. On 09/19/24 at 12:51 PM, during an interview with R #94's FM, the following was stated: 1. POA notified FM (unknown date) R #94 was combative during brief change and asked him to check on R #94. 2. The bruise and the scratches were not small at all and looked big. 3. R #94 had a bruise to her face and to her neck. T. On 09/19/24 at 2:47 PM, during an observation of R #94 the following was revealed: 1. R #94's index finger and middle finger on her left hand had a two-inch cut and an abrasion (a superficial injury to the skin or other body tissue caused by rubbing or scraping). 2. R #94's right hand had a cut between the thumb and the index finger in a U shape. 3. R #94's right cheek and right side of her neck had a purplish and green bruise about two inches in width and five inches in length. U. On 09/20/24 at 9:21 AM, during an interview with LPN #24 she stated the following: 1. On 09/12/24 she came into her shift from 6 AM to 2 PM. 2. During shift change approximately between 6 AM and 6:30 AM, RN #24 informed her R #94 became combative during brief change. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. R #94 obtained skin tears to both of her left and right hand (bilateral). 4. RN #24 medicated R #94 with morphine and lorazepam and dressed her wounds. 5. R #94 slept through breakfast and was checked on by a CNA. 6. The CNA saw the bruises and injuries on R #94, and she (LPN #24) assessed R #94 and reported the incident to the unit manager, the administrator and the DON on 09/12/24 at 12:15 PM. V. On 09/20/24 at 10:42 AM, during an interview with CNA #25 she stated the following: 1. On 09/12/24 (between 5:00 am-6:00 am), CNA #25 was told by RN #24 hurry up and get in here in R #94 room. 2. CNA #25 walked into R #94's room and saw blood everywhere; bed sheets, shirt and floor and on RN #24 hands and upper arms. 3. CNA #25 asked RN #24 what happened and was told by RN #24 I have to do wound care on her and RN #24 did not provide more information. 4. RN #24 and herself CNA #25 worked the night shift when incident happened. 5. CNA #25 did not report what she observed to anyone. W. On 09/24/24 at 8:34 AM, during an interview with the unit manager, she stated when LPN #24 reported the incident to the unit manager, she instructed LPN #24 to contact the administrator and start a report for R #94 [she did not elaborate on time frames or follow up]. X. Record review of the facility's Abuse Questionnaire to the residents completed by facility staff on 09/24/24 revealed R #51 stated the tall nurse at night hurt my roommate (R #94), she caused the blue on her arms, she did that. I forgot to tell. The above findings resulted in an Immediate Jeopardy that was called on 10/28/24 at 6:15 PM The facility submitted a final plan of removal on 10/28/24 at 6:39 PM which replicated effort previously made and verified for the F609 IJ on 09/25/24. Plan of Removal .The following identification/corrections will be completed by 09/25/24: -A full abuse investigation will occur within the facility with staff, residents and families of those who are unable to speak for themselves to ensure no other residents have witnessed abuse or been abused. Descriptors of abuse will be updated on the Facility Abuse Questionnaires to include simplified examples of abuse as needed, so that residents understand or are able to answer questions. -If any further potential abuse, neglect, exploitation, or mistreatment are brought forward the facility will immediately remove the resident from the situation, and ensure they are safe, and reportable filed with the state. If a staff member is identified as the alleged perpetrator, they will be suspended immediately, pending a thorough investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-A quiz will be given to all staff members after education to ensure the abuse process is retained. The quiz will include who the staff notifies upon alleged abuse identification (the abuse coordinator or DON), and when they notify (immediately). -Staff will be provided the corporate compliance telephone number to anonymously report allegations or suspected abuse if they are afraid to report to the abuse coordinator or DON. -An audit of current memory care residents' skin will occur to ensure that there are no unidentified signs of injury or abuse. If any concerns are noted, the change in condition process will be followed and notifications to the provider, family and abuse coordinator will occur to ensure monitoring occurs. A report to the state agency will occur as necessary. -The nurse in question was placed on Administrative leave at 10:30 am on September 12, 2024 and was not permitted back on site. She was terminated on September 16th after the investigation was complete . 50497

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Recite from 06/20/24 Based on observation, record review, and interview the facility failed to report alleged allegations of abuse to the State Agency for 4 (R #12, R #16, R #94 and R #117) of 5 (R #12, R #16, R #94, R #117 and R #133) residents sampled for abuse, when they failed to; 1. Report R #12's allegation of abuse within 2 hours. 2. Submit R #16's 5 day follow-up report to the state agency within 5 working days. 3. Report R #94's allegation of abuse within 2 hours 4. Report R #117's allegation of abuse within 2 hours If the facility fails to report allegations of abuse and the results of the investigations to the State Survey Agency, then corrective action may not be taken, and residents could likely suffer serious bodily injury. The facility's failure to report witnessed abuse of R #117 by RN #24 likely resulted in RN #24 being able to physically abuse R #94 a few hours later. The findings are: R #12 A. On 09/17/24 at 10:55 AM, during an interview with R #12, the following was stated: 1. About five weeks before the interview, she had fallen twice in the restroom. 2. She fell because CNA #16 told her she was lazy and could do more, so she went to the restroom by herself. 3. She does not want CNA #16 to help her. B. Record review of Abuse Questionnaire (questions the facility staff use to ask residents to determine if they have been abused), dated 08/09/24, revealed that R #12's sister told staff that CNA #16 speaks loudly not because resident is hard of hearing, but it's her tone, it's bossy, not right. C. Record review of Abuse Questionnaire, dated 08/09/24, revealed that R #66 (R #12's roommate) told staff that she does not like CNA #16 because she is mean and doesn't talk nice to R #12. D. Record review of Abuse Questionnaire, dated 08/09/24, revealed that R #5 told staff that CNA #16 was not helpful and bossed her around. E. On 09/25/24 at 3:32 PM, during an interview CNA #17, the following was stated: 1. R #12 is not supposed to transfer by herself. (continued on next page)

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	325047	A. Building B. Wing	10/28/2024

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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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. R #12 is selective about which CNAs she will allow to help her. 3. R #12 does not like CNA #16 to help her. 4. R #12 has told him that CNA #16 had called her lazy (was unsure of date). 5. R #12 is more likely to get up without assistance when CNA #16 is working, because she doesn't want CNA #16's help. 6. Several residents have told him that CNA #16 is mean to them and they don't like her. 7. R #73 told him that CNA #16 had called her lazy (was unsure of date). 8. A couple of months prior (unsure of the date) to the interview he told RN #16 and another LPN who is no longer working at the facility about CNA #16 calling the residents lazy. 9. He was unsure what was done after he reported the allegations to the nurses. F. On 09/25/24 at 3:49 PM, during an interview with RN #16, the following was stated: 1. On 08/13/24, R #12 told her that CNA #16 had told her she was lazy and needed to do things for herself. 2. On 08/13/24, RN #16 reported to the DON or ADON what R #12 said of CNA #16 telling R #12 she was lazy. 3. Administration made sure that CNA #16 did not work with R #12 anymore. 4. She had not been notified about any other incidents of CNA #16 telling residents that they were lazy prior to the report by R #12 on 08/13/24 5. She was not aware of any other residents who have had issues with CNA #16. G. On 09/26/24 at 4:14 PM, during an interview with the DON, the following was confirmed: 1. Staff calling a resident lazy would be considered abuse. 2. She became aware of CNA #16 calling R #12 lazy after speaking with R #12's sister after R #12 fell on [DATE]. 3. Prior to speaking with R #12's sister on 08/13/24, she had not been made aware of CNA #16 being rude or calling resident's lazy 4. If she had been made aware of CNA #16 calling resident's lazy prior to 08/13/24, the facility would have reported it to the SA, CNA #16 would have been suspended until her or the administrator completed an investigation. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Staff were expected to report any allegations of abuse to their charge nurse, unit manager, DON, or Administrator. 6. The expectation was for any nurse or unit manager who received an allegation of abuse to report it to the DON or Administrator. H. On 09/30/24 at 10:57 AM, during an interview with the Administrator, the following was revealed: 1. She had completed the abuse questionnaires from R #12's sister, R #66, and R #5 on 08/09/24 due to allegation of abuse. 2. She became aware of CNA #16 calling R #12 lazy after R #12's sister called her to report it on 08/13/24. 3. Prior to the report by R #12's sister on 08/13/24, she had not been made aware of CNA #16 calling residents lazy R #16 I. On 09/18/24 at 11:44 AM, during an interview, R #16 stated approximately one month ago (unsure of exact date) his ex-roommate hit him with a cane. R #16 stated that staff intervened during the incident, and his roommate was moved to another room. J. Record review of R #16's progress note dated 09/07/24 at 2:32 PM revealed R #16 and roommate had a physical altercation at approximately 8:45 AM, R #16 was hit in the face and head by roommate On assessment, resident has small area of localized inflammation (swelling to a confined area) to right zygomatic arch (cheek bone) and temple, and small area of tenderness and redness to the bridge of his nose. No open injuries or breaks to the skin . K. Record review of the facility's incident report revealed that the altercation between R #16 and his roommate was reported to the State Survey Agency on 09/07/24 at 10:05 AM. L. Record review of the facility's 5 day follow-up report (no date) revealed that R #16's roommate was moved to another room on 09/07/24 after the incident. The 5 day follow-up report was not sent to the State Survey Agency until 09/18/24 at 1:55 PM. M. On 09/27/24 at 10:35 AM, during an interview with the DON, she confirmed that the 5 day follow-up report for R #16's incident on 09/07/24 was sent to the State Survey Agency on 09/18/24 and was not sent within 5 working days of the incident. R #117 N. Record review of R #117 admission record revealed the following: 1. R #117 was admitted to the facility on [DATE]. 2. R #117 was diagnosed with unspecified psychosis not due to a substance or known physiological condition and other specified disorders of brain. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. On 09/19/24 at 2:56 PM, during an interview with CNA #24 he stated the following: 1. On 09/11/24 at 10 PM, he was walking out the Dementia unit and noticed RN #24 yelling at R #117 in an aggressive tone being confrontational and disrespectful. 2. CNA #24 saw RN #24 drag R #117 off the dining room chair and yelled at her, told her You can't sleep here; you need to go to your room. 3. He reported the incident to the unit manager on 09/12/24. P. On 09/20/24 at 9:52 AM, during an interview with R #117, she stated the following: 1. On multiple occasions RN #24 has hit me on my face, body, and nobody said anything because of repercussions (an unintended consequence occurring some time after an event or action, especially an unwelcome one). 2. She feels that RN #24 has degraded her by telling her she had no value, and she was useless. R #117 did not provide detail of how many times this has happened. 3. She was asleep on the dining room chair and RN #24 pulled her up and told her You will not be falling asleep here and sat her back down. R #117 did not provide further information. Q. Record review of the facility's Abuse Questionnaire to the residents completed by facility staff on 09/24/24 revealed R #117 stated I have a threat from staff, she has not worked a shift with me, it's been addressed, this woman is dangerous [referring to RN #24]. R. On 09/24/24 at 8:34 AM, during an interview with the unit manager, she stated staff did not report the incident with R #117 and she did not know anything about the incident. S. On 09/24/24 at 2:38 PM, during an interview with CNA #24, he stated the following: 1. He reported the incident between R #117 and RN #24 to the unit manager during his shift on 09/12/24 at 2 PM. 2. He was told by the unit manager to complete a written statement, he completed the statement and turned it in to the unit manager on 09/12/24 around 2:30 PM. 3. On 09/12/24 during his 2 PM shift, R #117 told him Last night she (RN #24) dragged me off the chair. R #117 was having behaviors and would not allow staff to provide care telling them I don't trust you all on 09/12/24. R #94 T. Record review of R #94's admission record revealed the following: 1. R #94 was admitted to the facility on [DATE]. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. R #94 was diagnosed with unspecified Dementia (diagnosis given a person has dementia but it can't be classified as a specific type) unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. U. Record review of R #94's nursing progress notes revealed the following: 1. On 9/12/2024 at 6:36 AM, note written by RN #24 stated [Name of R #94] became very agitated while being changed, hitting, scratching, kicking, and trying to bite staff, very combative and yelling that we were trying to kill her. She had pulled off her nasal cannula and became more combative while staff put it back in place thrashing her head back and forth and screaming. She sustained skin tears to both hands and one on her left wrist. Skin tears cleaned and dressed with her resisting care and trying to tear the dressings back off. 2. According to nurse's progress note written by RN #24 revealed no other staff was present at time of the incident. 3. On 09/12/24 at 1:11 PM, note written by LPN #24 stated, during morning report, night nurse reported [Name of R #94] was being combative during brief change and [Name of R #94] had obtained skin tears to bilateral (both) hands and left wrist. [Name of R #94] was medicated with as needed medications for pain and anxiety by night nurse. [Name of R #94] slept through breakfast. CNA went to get [Name of R #94] up for lunch and noted large bruise to right side of face and reported to nurse. [Name of R #94] was assessed for further injuries and noted to bruises to right calf. Skin tears cleansed and wrapped and covered with gauze. Medicated [Name of R #94] with morphine as needed. Called Power of Attorney (POA) and notified of change in condition, called Hospice twice and no response. Notified physician about change in condition. 4. Staff did not document any other progress notes in the previous months of R #94 being combative with any staff except for RN #24 on 09/12/24 during brief change. V. On 09/19/24 at 12:42 PM, during an interview with R #94's Power of Attorney (POA) she stated the following: 1. Family Member (FM) was informed by LPN #24, that R #94 was hitting and biting. 2. R #94 obtained some small cuts on her hands. 3. R #94 obtained a small bruise on her cheek. W. On 09/19/24 at 12:51 PM, during an interview with R #94's FM, the following was stated: 1. POA notified FM (unknown date) R #94 was combative during brief change and asked him to check on R #94. 2. The bruise and the scratches were not small at all and looked big. 3. R #94 had a bruise to her face and to her neck. X. On 09/19/24 at 2:47 PM, during an observation of R #94 the following was revealed: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. R #94's index finger and middle finger on her left hand had a two-inch cut and an abrasion (a superficial injury to the skin or other body tissue caused by rubbing or scraping). 2. R #94's right hand had a cut between the thumb and the index finger in a U shape. 3. R #94's right cheek and right side of her neck had a purplish and green bruise about two inches in width and five inches in length. Y. On 09/20/24 at 9:21 AM, during an interview with LPN #24, she stated the following: 1. On 09/12/24, LPN #24 came onto her shift from 6 AM to 2 PM. 2. During shift change meeting approximately between 6 AM and 6:30 AM, RN #24 informed her R #94 became combative during brief change. 3. R #94 obtained skin tears to both of her left and right hand (bilateral). 4. RN #24 medicated R #94 with morphine and lorazepam and dressed her wounds. 5. R #94 slept through breakfast and was checked on by a CNA. 6. The CNA saw the bruises and injuries on R #94, and she (LPN #24) assessed R #94 and reported the incident to the unit manager, the administrator and the DON on 09/12/24 at 12:15 PM. Z. On 09/20/24 at 10:42 AM, during an interview with CNA #25 she stated the following: 1. On 09/12/24 (between 5:00 am-6:00 am), CNA #25 was told by RN #24 hurry up and get in here in R #94 room. 2. CNA #25 walked into R #94's room and saw blood everywhere; bed sheets, shirt and floor and on RN #24 hands and upper arms. 3. CNA #25 asked RN #24 what happened and was told by RN #24 I have to do wound care on her and RN #24 did not provide more information. 4. RN #24 and herself CNA #25 worked the night shift when incident happened. 5. CNA #25 did not report what she observed to anyone. AA. On 09/24/24 at 8:34 AM, during an interview with the unit manager, she stated when LPN #24 reported the incident, she instructed LPN #24 to contact the administrator and start a report for R #94 [she did not elaborate on time frames or follow up]. BB. Record review of the facility's Abuse Questionnaire to the residents completed by facility staff on 09/24/24 revealed R #51 stated the tall nurse at night hurt my roommate (R #94), she caused the blue on her arms, she did that. I forgot to tell. The above findings resulted in an Immediate Jeopardy that was called on 09/24/24 at 5:48 PM (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility submitted a final plan of removal on 09/25/24 and implementation was verified onsite. Plan of Removal .The following identification/corrections will be completed by 09/25/24: -A full abuse investigation will occur within the facility with staff, residents and families of those who are unable to speak for themselves to ensure no other residents have witnessed abuse or been abused. Descriptors of abuse will be updated on the Facility Abuse Questionnaires to include simplified examples of abuse as needed, so that residents understand or are able to answer questions. -If any further potential abuse, neglect, exploitation, or mistreatment are brought forward the facility will immediately remove the resident from the situation, and ensure they are safe, and reportable filed with the state. If a staff member is identified as the alleged perpetrator, they will be suspended immediately, pending a thorough investigation. -A quiz will be given to all staff members after education to ensure the abuse process is retained. The quiz will include who the staff notifies upon alleged abuse identification (the abuse coordinator or DON), and when they notify (immediately). -Staff will be provided the corporate compliance telephone number to anonymously report allegations or suspected abuse if they are afraid to report to the abuse coordinator or DON. -An audit of current memory care residents' skin will occur to ensure that there are no unidentified signs of injury or abuse. If any concerns are noted, the change in condition process will be followed and notifications to the provider, family and abuse coordinator will occur to ensure monitoring occurs. A report to the state agency will occur as necessary . 49313 50497

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure the Minimum Data Set Assessment (MDS, part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment) was accurate for 2 (R #12 and R #14) of 10 (R #12, R #13, R #14, R #20, R #23, R #40, R #60, R #81, R #118 and R #292) residents review for MDS assessment accuracy. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: R #12 A. On 09/17/24 at 10:50 AM, during an interview with R #12, she stated that she had a Urinary Tract Infection (UTI) for the past couple of months. B. Record review of R #12's physician orders revealed the following: 1. Order date 04/16/24, ciprofloxacin HCL (antibiotic) 500 mg every 12 hours for suspected UTI for 5 days. 2. Order date 04/19/24, Macrobid (antibiotic) 100 mg every 6 hours for UTI for 5 days. C. Record review of R #12's Annual MDS dated [DATE], revealed staff did not document R #12 had a UTI within the past 30 days. D. On 09/26/24 at 3:53 PM, during an interview with the DON, she confirmed the following: 1. R #12 had orders for ciprofloxacin on 04/16/24 and Macrobid on 04/19/24 to treat a UTI. 2. Staff documented in the Annual MDS, dated [DATE], that R #12 did not have a UTI within the previous 30 days. 3. Staff should have documented in the Annual MDS dated [DATE], that R #12 had a UTI within the previous 30 days. R #14 E. On 09/21/24 at 10:21 AM, during an interview with R #14, she stated she had a feeding tube (Percutaneous Endoscopic Gastrotomy Tube/PEG; medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate). F. Record review of R #14's physician's orders (multiple dates) revealed the following: Order date 07/15/24, flush PEG tube twice daily with 60 ml of water. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Record review of R #14's Medicare 5-day MDS assessment dated [DATE], revealed that staff did not document that R #14 received fluid via her PEG tube. H. On 09/27/24 at 9:50 AM, during an interview with RN #1, she confirmed R #14 had a PEG tube since her initial readmission on 08/10/24. I. On 09/27/24 at 10:40 AM, during an interview with the MDS LPN, she confirmed that R #14's PEG tube flushes were not captured on her readmission (Medicare 5-day) MDS assessment. 49313

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview the facility failed to develop and implement a comprehensive person-centered care plan for 2 (R #14 and R #123) of 8 (R #14, R #16, R #29, R #40, R #118, R #123, R #292 and R #293) residents reviewed for care plans. Failure to develop and implement a resident centered care plan may result in staff's failure to understand and implement the needs and treatments of residents possibly resulting in worsening of medical condition. The findings are: R #14 A. On 09/21/24 at 10:21 AM, during an interview with R #14, she stated she had a feeding tube (Percutaneous Endoscopic Gastrotomy Tube/PEG; medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) B. Record review of R #14 Admission Record (no date) revealed the following. 1. Initial admitted [DATE]. 2. Readmitted [DATE]. 3. Diagnosis: Gastrostomy status (presence of an artificial opening to the stomach). C. Record review of R #14's physician's orders revealed an order dated 07/15/24, flush PEG tube twice daily with 60 ml of water. D. Record review of R #14's care plan dated 07/08/24 revealed the care plan did not contain a care plan for care of R #14's PEG tube. E. On 09/27/24 10:04 AM, during an interview with the DON, she confirmed that R #14's care plan did not include care for the PEG tube. R #123 F. Record review of R #123's Admission Record (no date) revealed an admitted [DATE]. G. Record review of R #123's Admission MDS (comprehensive assessment) dated 06/11/24 revealed R #123 had two unstageable deep tissue injuries (pressure ulcer or bed sore where the depth of the wound is obscured by a layer of dead tissue). H. Record review of R #123's care plan dated 06/10/24 revealed the care plan did not contain a plan in for care of R #123's unstageable deep tissue injuries. I. On 09/27/24 10:09 AM, during an interview with the DON, she confirmed that R #123's care plan did not include care for R #123's unstageable deep tissue injuries.

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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** 41755 Recite from 06/20/24 Based on record review, observation, and interview, the facility failed to ensure care plans were reviewed and revised for 9 (R #4, R #12, R #45, R #60, R #81, R #109, R #110, R #111, and R #118) of 9 (R #4, R #12, R #45, R #60, R #81, R #109, R #110, R #111, and R #118) residents reviewed for care plans when they failed to: 1. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) members participate in the care plan meeting for R #4, R #45, R #60, R #81, and R #109. 2. Have the care plan meeting within seven days after the completion of the Minimum Data Set assessment (MDS, part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment) for R #60 and R #81. 3. Revise the care plan with the most current resident information for R #4, R #12, R #81, R #110, R #111, and R #118. These deficient practices could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: IDT Team R #4 A. Record review of R #4's care plan meeting note, dated 07/23/24, revealed the staff that were present for the meeting were: UM #16, the Activities Director (AD), and the Social Services Assistant (SSA). R #45 B. Record review of R #45's care plan meeting note, dated 07/03/24, revealed the staff that were present for the meeting were: UM #16, LPN #40, AD, and the SSA, and the SSD. R #60 C. Record review of the care plan meeting note, dated 06/20/24, revealed the staff that were present for the meeting were: UM #16, the AD, the SSD, and the SSA. (continued on next page)

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Casa DE Oro Center	1005 Lujan Hill Road Las Cruces, NM 88005

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #81 D. Record review of the care plan meeting note, dated 06/06/24, revealed the staff that were present for the meeting were: UM #16, the AD, the SSD, and the SSA. R #109 E. Record review of R #109's care plan meeting note dated 08/22/24, revealed the staff that were present for the meeting were: UM #16, the DON, the AD, the SSD, and the SSA. F. On 09/26/24 at 3:39 PM, during an interview with the DON, the following was stated: 1. The SSA attended the care plan meetings as a CNA. 2. The SSA works all the floors in the facility. 3. The UM does not provide direct resident care. 4. Providers do not attend the care plan meetings unless the resident or their representative request their attendance. G. On 09/30/24 at 11:40 AM, during an interview with the SSA, the following was confirmed: 1. She is a CNA. 2. She attended the care plan meetings as the SSA, not a CNA. 3. She has worked one of the halls in the facility but has not worked the other halls. 4. She was not familiar with the daily care of the residents who are on halls other than the hall she works. H. On 09/30/24 at 11:44 AM, during an interview with the SSD, the following was confirmed: 1. UM #16 attended the care plan meeting as the nurse and provides the information about the resident's care. 2. The providers are not invited to the care plan meeting unless the resident or their representative request for the provider to be present. 3. They do not contact the providers for input prior to the care plan meetings. I. On 09/30/24 at 11:52 AM, during an interview with UM #16, the following was confirmed: 1. She attended the care plan meetings as the nurse. 2. She pulled notes from resident records to provide information at the care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. She would not be familiar with changes in the resident status and daily care if it was not documented in the medical record. Care Plan Timing R #60 J. Record review of R #60's admission record, no date, revealed R #60 was admitted to the facility on [DATE]. K. On 09/17/24 at 11:10 AM, during an interview with R #60, she stated she didn't think she had been invited or attended a care plan meeting since admission. L. Record review of R #60's MDS assessments, multiple dates, revealed the following: 1. Staff completed a quarterly MDS assessment for R #60 on 03/04/24. 2. Staff completed a quarterly MDS assessment for R #60 on 05/30/24. 3. Staff completed an annual MDS assessment for R #60 on 08/26/24. M. Record review of progress notes, dated 01/01/24 through 09/20/24, revealed the following: 1. Staff did not complete a care plan meeting after R #60's quarterly MDS assessment was completed on 03/04/24. 2. R #60 had a care plan meeting on 06/20/24 (not within 7 days of the quarterly MDS assessment completed on 05/30/24). 3. Staff did not complete a care plan meeting after R #60's annual MDS assessment was completed on 08/26/24. N. On 09/26/24 at 3:39 PM, during an interview with the DON, the following was confirmed: 1. Care plan meetings are expected to occur within 7 days of the completion of the MDS assessment. 2. R #60 should have had a care plan meeting after the completion of the MDS assessment on 03/04/24. 3. R #60 had one care plan meeting on 06/20/24 which was not within 7 days after the MDS assessment that was completed on 05/30/24. 4. R #60 should have had a care plan meeting after the completion of the MDS assessment on 08/26/24. R #81 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. Record review of R #81's admission record, no date, revealed R #81 was admitted to the facility on [DATE]. P. On 09/16/24 at 2:55 PM, during an interview with R #81, she stated she had not been invited or attended a care plan meeting since admission. Q. Record review of R #81's MDS assessments, multiple dates, revealed the following: 1. Staff completed a quarterly MDS assessment for R #60 on 03/05/24. 2. Staff completed a quarterly MDS assessment for R #60 on 05/28/24. 3. Staff completed an annual MDS assessment for R #60 on 08/27/24. R. Record review of progress notes, dated 01/01/24 through 09/20/24, revealed the following: 1. Staff did not complete a care plan meeting after R #60's quarterly MDS assessment was completed on 03/05/24. 2. R #81 had a care plan meeting on 06/06/24 (not within 7 days of the quarterly MDS assessment completed on 05/28/24). 3. R #81 had a care plan meeting on 09/05/24 (not within 7 days of the quarterly MDS assessment completed on 08/27/24). S. On 09/26/24 at 3:45 PM, during an interview with the DON, the following was confirmed: 1. Care plan meetings are expected to occur within 7 days of the completion of the MDS assessment. 2. R #81 had two care plan meetings: a. R #81 should have had a care plan meeting after completion of the MDS assessment on 03/05/24. b. A care plan meeting was held on 06/06/24 which was not within 7 days after the MDS assessment that was completed on 05/28/24. c. A care plan meeting was held on 09/05/25 which was not within 7 days after the MDS assessment completed on 08/27/24. Care Plan Revisions R #4 T. Record review of R #4's admission record revealed R #4 was admitted to the facility on [DATE]. U. Record review of R #4's physician's orders dated 12/19/23 revealed oxygen, 2 liters via nasal canula as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Record review of R #4's care plan dated 07/08/24 revealed the oxygen and interventions for the oxygen are not care planned for. R #12 W. On 09/17/24 at 10:52 AM, during an observation and interview with R #12, the following was revealed: 1. She had frequent diarrhea that doesn't give her time to go to the restroom. 2. She takes a liquid medication in the morning to stop the diarrhea. 3. Sometimes she has trouble using the restroom because she has constipation. 4. She had a bandage to her right heel. 5. She was unsure how frequently staff change the dressing to her heel. X. Record review of R #12's physician orders (multiple dates), revealed the following: 1. An order dated 02/02/24 through 07/14/24, for Miralax (a laxative that can treat occasional constipation) daily for constipation. 2. An order dated 07/11/24, for Metamucil (a fiber supplement that supports digestive help and maintains bowel regularity) to be given daily for intermittent diarrhea and constipation. 3. An order dated 07/14/24, for Miralax as needed for constipation. 4. An order dated 09/24/24, to apply heel protectors to bilateral feet or elevate feet with pillow at all times while in bed. Y. Record review of R #12's skin assessments multiple dates, revealed the following: 1. On 08/16/24, R #12 had bruising to her right heel. 2. On 09/10/24, R #12 had bruising to her right heel. Z. On 09/25/24 at 3:20 PM, during an interview with RN #16, the following was stated: 1. R #12 had a deep tissue injury on her right heel. 2. The wound looks like she had a blister that burst, and it is dry. 3. Staff are cleansing wound and placing Mepilex (an absorbent foam dressing to manage a wide range of chronic and acute wounds) to cover the closed wound. 4. Confirmed R #12 does not have any orders for wound care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NN. Record review of R #118's Admission Record (no date) revealed the following. 1. admitted [DATE]. 2. Diagnosis: Obstructive and reflex uropathy (blockage that prevents urine from flowing naturally through the urinary system). OO. Record review of R #118's physician's orders revealed: Order date 07/03/24, replace drainage system if disconnections or leakage occur as needed for foley care (process of caring for a Foley catheter, a flexible tube that drains urine from the bladder). PP. Record review of R #118's progress notes revealed: 1. Nurse note dated 09/17/24 11:40 AM, R #118 reported pain in peri area (perineum, area of the body between the anus and the genitals). Urinary catheter was set up for flush (procedure that involves rinsing out a catheter to remove debris and keep it clean) using aseptic technique (method used to prevent contamination with microorganisms). When attached to flush catheter was very resistant. Catheter was not able to be flushed due to resistance, catheter was removed. Catheter insertion was attempted using sterile technique, attempt failed. 2. Nurse note 09/17/24 10:04 PM catheter not in. 3. Nurse note 09/18/24 6:58 AM no foley catheter in place 4. Nurse note 09/18/24 1:56 PM no foley in place. 5. Nurse note 09/18/24 9:03 PM does not have foley catheter at this time. 6. Nurse note 09/19/24 5:08 AM does not have foley catheter at this time. QQ. Record review of R #118's care plan dated 06/28/24 revealed R #118 required indwelling (medical devices that are left inside the body to perform a function such as draining urine) foley catheter. RR. On 09/27/24 10:14 AM, during an interview with the DON, she confirmed that R #118's care plan should have been updated when R #118's foley catheter was removed to show that she no longer had a foley catheter in place. 47510 49313

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #23) of 1 (R #23) residents reviewed for hospice services, when they failed to ensure the facility received documentation regarding the services provided to R #23 by hospice staff. This deficient practice could likely lead to staff not being aware of the services that are provided by the hospice staff and residents needs not being met and/or a worsening of their condition. The findings are: A. Record review of R #23's admission record, no date, revealed R #23 was admitted to the facility on [DATE]. B. Record review of R #23's physician's order, dated 06/12/23, revealed an order for hospice services. C. On 09/24/24 at 12:06 PM, during an interview with LPN #16, the following was stated: 1. Hospice staff were supposed to provide a bed bath to R #23 three times a week. 2. The hospice nurse was supposed to come at least once a week. 3. Hospice staff were expected to fax documents about the care they provided to residents after each visit. 4. The facility had a hospice binder located at the nurses station for each resident who received hospice care. 5. Facility staff were expected to put documents received from hospice in the resident's hospice binder. 6. He was unable to determine the last time hospice staff saw R #23. D. Record review of R #23's hospice binder, revealed that the most recent documentation located in the hospice binder was a hospice care plan dated 10/20/23. E. Record review of R #23's electronic medical record, no date, revealed that the most recent document from hospice was a hospice care plan dated 07/26/24. F. On 09/24/24 at 12:19 PM, during an interview with LPN #16, the following was stated: 1. He confirmed that R #23's hospice binder did not have any documentation since 10/20/23. 2. He was unsure where to get current information related to the hospice services that have been provided to R #23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 09/26/24 at 3:28 PM, during an interview with the DON, the following was confirmed: 1. Hospice staff complete their documentation through hospice documentation system. 2. Hospice staff are expected to fax or drop off the documents about the care that they provided. 3. Any documents that are received from hospice are expected to be scanned into the resident's chart and a copy placed in the resident's hospice binder located at the nurses station. 4. The last documentation received from hospice for R #23's care was a Hospice Care Plan dated 07/26/24. 5. She was unable to determine the last time hospice staff provided care to R #23 or what care or services have been provided. 6. The expectation would be for the hospice facility to provide documentation to the facility within a reasonable timeframe, at least weekly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 49313 Based on observation, interview, and record review, the facility failed to keep residents free from accidents for 1 (R #12) of 1 (R #12) residents reviewed for falls, when staff failed to identify and implement interventions to prevent R #12 from falling. This deficient practice could likely result in residents being at risk of serious harm or injury. The findings are: A. Record review of R #12's admission record, no date, revealed the following: 1. R #12 was admitted to the facility on [DATE]. 2. R #12 had the following diagnoses: a. Encephalopathy (a broad term for any brain disease that alters brain function or structure). b. Type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). c. Morbid obesity due to excess calories (a disorder that involves having too much body fat, which increases the risk of health problems). d. Unspecified dementia, unspecified severity, with psychotic disturbance (a loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). B. On 09/17/24 at 10:55 AM, during an interview, R #12 stated the following: 1. She fell in the restroom twice about five weeks ago. 2. The CNA left her in the restroom alone one time and she fell when she tried to put on her brief and get in her wheelchair and the wheelchair moved. 3. The second time she fell when staff did not come when she rang the call bell so she went to the restroom by herself. C. Record review of R #12's nursing progress note, dated 08/13/24 at 10:00 AM, revealed the following: 1. R #12 fell in the restroom. 2. CNA told R #12 that she was going to help another resident and advised R #12 to call for assistance when she was finished using the restroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R #12 thought the CNA had left. 4. R #12 tried to pull up her pants and reached for the wheelchair. The wheelchair moved and caused the resident to fall. 5. R #12 reported pain to her right mid-lower back. 6. X-rays were ordered. D. Record review of R 12's nursing progress note, dated 08/13/24 at 4:23 PM, revealed the following: 1. R #12 fell in the restroom for the second time that day. 2. R #12 told the nurse that she attempted to toilet herself independently. The resident stated her left leg was not strong enough, and she fell . 3. R #12 reported pain in both knees. 4. Staff educated R #12 to use the call light at all times when transferring herself. E. Record review of R #12's quarterly MDS assessment, dated 07/30/24, revealed the following functional abilities: 1. Sit to stand: Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) needed. 2. Chair/bed-to-chair transfer: Supervision or touching assistance needed. 3. Toilet transfer: Supervision or touching assistance needed. F. Record review of R #12's care plan, revised on 08/15/24, revealed the following: 1. On 04/28/23, staff revised R #12's care plan to include that she was at risk for falls. a. Staff revised R #12's care plan interventions to include that staff are to provide the following verbal cues for safety and sequencing (arrange in a specific order) when needed (staff did not include what verbal cues or sequence staff are to use). b. Staff did not document that R #12's was expected to use the call light when transferring. 2. On 04/29/23, staff revised R #12 care plan to include that R #12 required assistance for mobility. a. The following interventions were in R #12's care plan related to mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Provide resident/patient with (specify: independently, with set-up, supervision, partial assist, substantial assist) assistance to move from sitting on side of bed to laying flat on bed (staff did not specify what level of assistance R #12 required). ii. Provide resident/patient with assistance (specify: independently, with set-up, supervision, partial assist, substantial assist) to safely move from laying on the back to sitting on the side of the bed with feet flat on the flat and no back support (staff did not specify what level of assistance R #12 required). iii. Provide resident/patient with assistance (specify: independently, with set-up, supervision, partial assist, substantial assist) to safely transfer to and from a bed to a chair (or wheelchair) (staff did not specify the level of assistance R #12 required). G. Record review physiatry (a branch of medicine that aims to enhance and restore functional ability and quality of life to people with physical impairments or disabilities) progress note, dated 07/01/24, revealed the resident was a fall risk. H. On 09/25/24 at 3:32 PM, during an interview, CNA #17 stated the following: 1. R #12 was not supposed to transfer by herself. 2. R #12 was selective about what CNAs she would allow to help her. 3. R #12 did not like CNA #16 to help her. 4. R #12 told him CNA #16 called her lazy (was unsure of date). 5. R #12 was more likely to get up without assistance when CNA #16 worked because she did not want CNA #16's help. I. On 10/02/24 at 1:51 PM, during an interview, the DON stated the following: 1. R #12's fall prevention interventions that were in place for R #12 prior to her fall on 08/13/24 were: a. Keep her bed in a low position. b. Provide verbal cues and sequencing. c. Keep R #12 in the dining area with staff. d. Encourage R #12 to attend activities. e. Was unable to state what verbal cues or sequence staff are expected to use for R #12. f. On 08/15/24, staff revised R #12's care plan to include staff to encourage R #12 to use the call light prior to transferring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Prior to her fall on 08/13/24, R #12 was expected to use her call light when she wanted to transfer. h. Prior to her fall on 08/13/24, R #12's care plan should have included the intervention for her to use her call light when she wanted to transfer.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observation, record review, and interview, the facility failed to ensure proper management of enteral tubes (a device utilized to provide liquid nutrition, hydration and medications via a tube into the stomach or intestine) for 2 (R #13 and R #14) of 2 (R #13 and R #14) residents reviewed for tube feeding when they failed to: 1. Administer R #13's feeding during the times ordered by the physician. 2. Provide care for R #14's enteral tube insertion site (percutaneous endoscopic gastrostomy/PEG; medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate). These deficient practices could likely lead to malnutrition, weight loss, and infection. The findings are: R #13 A. Record review of R #13's admission record, no date, revealed the following: 1. R #13 was admitted to the facility on [DATE]. 2. R #13 had the following diagnoses: a. Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves). b. Adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol). c. Dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or throat). d. Hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided weakness that can limit movement and affect all basic activities) following unspecified cerebrovascular disease (conditions affecting blood flow to the brain) affecting right dominant side. B. Record review of R #13's physician's orders, multiple dates, revealed the following: 1. An order dated 10/17/22, staff may use Jevity 1.5 (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding), 1 carton bolus feed every 3 hours if Jevity 1.5 or 1.2 bottles are not available. 2. An order dated 05/21/24, for R #13's enteral feed to run at 75 ml per hour from 3:00 PM to 11:00 AM. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review of R #13's care plan, revised on 03/06/24, revealed staff were to administer feeding through the PEG tube as ordered. D. On 09/17/24 at 8:40 AM, during an observation of R #13's room, the resident's tube feeding machine was off and the room did not have any bottles or cartons of feeding in the room. E. On 09/18/24 at 8:30 AM, during an observation of R #13's room, the resident's tube feeding machine was off and the room did not have any bottles or cartons of feeding in the room. F. On 09/18/24 at 8:32 AM, during an interview, LPN #16 stated the following: 1. R #13's tube feeding was not currently running, because he turned it off about 15 minutes ago. He stated he was planning to hang it at 3:00 PM. 2. He was unsure what time R #13's feeding was supposed to be stopped, but he believed it was supposed to be stopped at 9:00 AM. 3. He confirmed he was R #13's nurse on 09/17/24 and stopped her feeding prior to 8:30 AM on 09/17/24. 4. He confirmed R #13 had orders for her tube feeding to run until 11:00 AM and restarted at 3:00 PM. G. On 09/26/24 at 3:36 PM, during an interview, the DON stated the following: 1. R #13 had an order for tube feeding to be hung at 3:00 PM and turned off at 11:00 AM. 2. Staff were expected to follow the physician's orders and ensure the tube feeding ran during the ordered times. 3. Not running the tube feeding as ordered could lead to the resident not meeting her nutritional requirements and weight loss. R #14 H. On 09/21/24 at 10:21 AM, during an interview with R #14, she stated she had a PEG tube I. On 09/27/24 at 9:50 AM, during an interview with RN #1, she stated R #14 was readmitted on [DATE] and had a PEG tube. J. Record review of R #14's care plan dated 07/08/24 revealed the care plan did not have care of R #14's PEG tube in place. K. On 09/27/24 at 10:05 AM, during an interview with NP #1, she stated she saw R #14 approximately 15 minutes ago and noted R #14 did not have a dressing in place over her PEG tube site. She stated the area at the PEG tube site appeared crusty. NP #1 stated she gave RN #1 an order today (09/27/24) for PEG tube site care to be performed daily. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L. Record review of the physician's orders revealed: 1. An order for PEG tube dressing changes was not ordered prior to 09/27/24. 2. Order dated 09/27/24, for PEG tube dressing change. Cleanse wound with normal saline, pat dry, and apply split gauze (precut gauze pads) to PEG tube insertion site, secure with tape one time daily. M. On 09/27/24 10:33 AM, during an interview with the DON, she confirmed R #14 did not have orders in place for the care of her PEG tube site prior to 09/27/24. 49313

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47510 Based on record review and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis (clinical purification of blood as a substitute for the normal function of the kidney) facility regarding dialysis care and failed to monitor the resident before and after dialysis treatment for 1 (R #111) of 1 (R #111) residents reviewed for dialysis care. This deficient practice could likely result in the facility being unaware of the resident's condition, possible complications that arise during dialysis treatment, and residents may not receive the appropriate monitoring and care. The findings are: A. Record review of R #111's admission record, no date, revealed R #111 had a diagnosis of end stage renal disease (ESRD; chronic irreversible kidney failure). B. Record review of R #111's physician orders revealed an order, revision date 07/22/24, for resident to have dialysis Monday, Wednesday, and Friday at 09:45 AM. C. Record review of R #111'S Electronic Medical Record (EMR) revealed: 1. Dialysis Communication Record, dated 09/02/23, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. 2. Dialysis Communication Record, dated 09/06/24, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. 3. Dialysis Communication Record, dated 09/11/24, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. 4. Dialysis Communication Record, dated 09/13/24, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. 5. Dialysis Communication Record, dated 09/16/24, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. 6. Dialysis Communication Record, dated 09/18/24, the facility completed pre-dialysis information, and the dialysis center completed dialysis information. The form did not include any post dialysis information, monitoring, or assessments. D. On 09/23/24 at 11:13 AM, during an interview, the DON stated a nurse should complete the dialysis communication sheets when R #111 leaves for dialysis and when the resident returned from dialysis. The DON confirmed the dialysis communication sheets were not completed on the above dates.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49313 Based on observation, record reviews and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of 2 (R #12 and R #66) of 2 (R #12 and R #66) residents reviewed for staffing when staff failed to: 1. Get R #12 up and ready on the morning of 09/30/24. 2. Answer R #12's call bell within a timely manner. 3. Offer baths or showers to R #66 as scheduled. These deficient practices are likely to cause residents psychological distress, make them feel as if they are not valued, and negatively impact resident comfort. The findings are: R #12 A. On 09/30/24 at 11:11 AM, during an observation and interview with R #12, the following was revealed: 1. R #12 lay in bed and wore her pajamas. 2. R #12 stated staff did not get her out of bed yet. 3. R #12 stated she pressed the call bell for staff to change her wet brief and get her up (she was unsure how long she had been waiting). 4. R #12's call light was off. 5. She stated sometimes staff turned off the call bell, but did not ask her what she needed (she was unsure if staff had turned off her call light). 6. She stated she was currently wet (she was unsure how long she had been wet). 7. She stated it made her feel horrible and alone when she pressed the call bell and the staff did not respond. 8. R #12 pressed her call light at 11:12 AM. 9. Nursing Assistant (NA) #16 responded to the call light at 11:36 AM. B. On 09/30/24 at 11:36, during an interview, NA #16 stated the following: 1. R #12 usually gets up around 8:30 AM or 9:00 AM in the morning. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. She did not get R #12 up that morning, because they were short staffed and busy. 3. She stated there should be three CNA's working on R #12's unit, but that day there was only her and a CNA. R #66 C. On 09/26/24 at 1:07 PM, during an interview, CNA #18 stated the following: 1. The unit R #66 was on should have four CNAs working on it, but lately the facility only staffed three CNAs. One CNA was out on leave so there were two CNAs working on the unit during the 6:00 AM to 2:00 PM shift. 2. Residents frequently did not get showers, because the facility was short staffed. 3. They were short staffed on the unit that day. Residents on the unit who were scheduled for showers in the morning would not receive showers, because only he and a new NA were working the unit. D. On 09/26/24 at 1:18 PM, during an interview, R #66 stated the following: 1. Her showers were scheduled in the mornings on Mondays and Thursdays. 2. She was scheduled for a shower that morning. 3. The NA told her she would not get a shower that day, because she (NA) was busy. 4. When she missed a shower, she had to wait until her next scheduled shower day (09/30/24). 5. When there were only two CNAs working, they did not give the residents showers. 6. She frequently missed showers due to short staffing. E. Record review of R #66's shower sheets revealed the following: 1. Staff did not document R #66 received a shower or bath on 09/19/24. 2. Staff did not document R #66 received a shower or bath on 09/26/24. F. On 09/30/24 at 1:26 PM, during an interview, the DON stated the following: 1. Staff were expected to respond to call lights promptly. 2. Residents should not wait longer than 10 to 15 minutes after they pressed the call bell. 3. Residents should not miss showers unless they refused a shower, and staff should document it on the shower sheet. 4. CNAs are expected to notify the nurse when they are unable to perform resident care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The nurses are expected to step in and assist with resident care if the CNAs were unable to complete it.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47510 Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician or the physician provided a rationale for not following the consultant pharmacist's recommendation for 2 (R #6 and R #54) of 2 (R #6 and R #54) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are: R #6 A. Record review of R #6's pharmacy consultation report, dated 09/08/24, revealed R #6 had an as needed (PRN) order for lorazepam (medication used to treat anxiety), which was in place longer than 14 days without a stop date. The recommendation was for a clinical rationale for continuation. B. Record review of R #6's physician's orders, dated 08/02/24, no end date, revealed an order for lorazepam 0.5 mg, every four hours as need for anxiety. C. Review of R #6's Electronic Medical Record (EMR) did not provide any additional information regarding the indication for continued use or rationale on why the pharmacist recommendation was not implemented. D. On 09/19/24 at 9:47 AM, during an interview, the DON confirmed there was not documentation of a rationale for PRN for more than 14 days or the continued use of the lorazepam. R #54 E. Record review of R #54's pharmacist medication review progress notes revealed the following:- Dated 08/11/24 and 09/04/24, had recommendations, see report and did not specify what recommendations. G. On 09/30/24 at 10:36 AM, during an interview with the DON she stated she did not receive R #54's drug regimen review back from the provider for August 2024, and she was still waiting for September's drug regimen review for R #54. 50497

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers) unless the medication was necessary to treat a specific psychiatric diagnosis (mental illness, symptoms or condition that greatly disturbs your thinking, moods, and/or behavior) for 2 (R #6 and R #54,) of 5 (R #6, R #14, R #26, R #40 and R #54,) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are: R #6 A. Record review of R #6's physician's order, start date 08/02/24, quetiapine (antipsychotic medicine indicated for the treatment of schizophrenia, bipolar I disorder manic episodes, and bipolar disorder depressive episodes) tablet Give 50 ml by mouth one time a day for depression. B. Record review of R #6's Medical Record revealed the resident did not have a psychiatric diagnosis to indicate the need for an antipsychotic. C. On 09/19/24 at 9:47 PM, during an interview, the DON confirmed R #6 did not have a psychiatric diagnosis for the antipsychotic medication. The DON stated the physician ordered the antipsychotic medication for R #6's depression. R #54 D. Record review of R #54's admission record revealed R #54 was admitted to the facility on [DATE] with the following diagnoses: 1. Dementia in other diseases classified elsewhere, severe, with other one other behavioral disturbance. 2. Major depressive disorder (a serious mood disorder that causes a persistent depressed mood and loss of interest in activities) , recurrent, moderate. 3. Obsessive-compulsive disorder (a personality disorder characterized by excessive orderliness, perfectionism, attention to details, and a need for control in relating to others.) E. Record review of R #54's care plan, dated 08/05/24, revealed R #52 was at risk for complications related to the use of psychotropic drugs. R #54 will have the smallest dose without side effects times 90 days. Administer the medication as ordered by provider. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #54's physician orders revealed R #54 took ziprasidone (is used to treat symptoms of psychotic (mental) disorders, such as schizophrenia, mania, or bipolar disorder.) 20 mg by mouth at bedtime for dementia with behaviors. Order date 04/02/2024. G. Record review of R #54's MDS, dated [DATE], revealed active diagnoses of non-Alzheimer's dementia and depression (other than bipolar). H. Record review of R #54's psychiatry progress notes, dated 05/26/24, revealed R #54 was diagnosed with major depressive disorder, recurrent, moderate. I. On 09/30/24 at 10:31 AM, during an interview with the DON, she stated the following: 1. She would expect to see a different diagnosis and did not provide detail. 2. She stated some providers use ziprasidone for dementia, but the psychiatric note was not very clear what the medication was for. 3. Asking the provider what ziprasidone was for would be a good question for the surveyor. J. On 10/02/24 at 2:50 PM, during an interview with the Medical Director, she stated the following: 1. R #54 currently saw a local psychiatrist. 2. She stated she would write an order for ziprasidone for schizophrenia or bipolar disorder but not for dementia. She stated she was not a psychiatrist and was only giving her medical opinion. 50497

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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. 47510 Based on observation and interview, the facility failed to properly store medications when they failed to: 1) Document temperatures for the East and [NAME] Unit medication refrigerators. 2) Secure a treatment cart that stored medications on the 500 Unit. These failures had the potential to affect all 127 residents in the facility (Residents were identified by the resident census provided by the Administrator on 09/16/24). These deficient practices could likely result in residents obtaining medications that are no longer effective or that are not prescribed to them resulting in adverse side effects. The findings are: East Unit and [NAME] Unit Medication Refrigerator A. Record review of the medication refrigerator temperature logs on the East Unit, for September 2024, revealed the following: 1. On 09/05/24, the temperature was 41 degrees. 2. On 09/06/24, the temperature was 44 degrees. 3. On 09/10/24, the temperature was 45 degrees. 4. On 09/11/24, the temperature was 42 degrees. 5. On 09/14/24, the temperature was 43 degrees. 6. On 09/25/24, the temperature was 44 degrees. 7. Staff did not document the temperature on any other days. B. On 09/26/24 at 11:26 AM, CMA #8 confirmed there were days on the logs when staff did not document the refrigerator temperatures. C. Record review of the medication refrigerator temperature logs on the [NAME] Unit, for 09/16/24 to 09/30/24, revealed the following: 1. On 09/16/24, the temperature was 48 degrees. 2. On 09/17/24, the temperature was 48 degrees. 3. On 09/18/24, the temperature was 48 degrees. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 09/19/24, the temperature was 48 degrees. 5. On 09/23/24, the temperature was 48 degrees. 6. Staff did not document the temperature on any other days for 09/19/24 to 09/25/24. 7. Temperature documentation was not available for 09/1/24 to 09/18/24. D. On 09/26/24 at 11:40 AM, during an interview, CMA #9 confirmed the missing dates on the temperature logs for [NAME] Unit refrigerator. E. On 09/26/24 at 11:44 AM, during an interview, the DON confirmed there were blank dates on the temperature log and was not sure if the temperatures were taken on those days or not. The DON said that the medication refrigerator temperatures should be checked daily and documented. Treatment Cart F. On 09/27/24 at 8:09 am, an observation of the 500 Unit revealed a treatment cart unlocked. G. On 09/27/24 at 8:09 am, during an interview, LPN #36 confirmed the treatment cart was unlocked. LPN #36 stated the treatment cart did not have a key. LPN #36 stated, If I lock it I wont be able to open it. H. On 09/27/24 at 8:44 am, an observation of the 500 Unit revealed a treatment cart unlocked, and staff were not present. I. On 09/27/24 at 8:49 am, during an interview, the DON confirmed the treatment cart was unlocked. The DON stated the treatment carts should be locked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47510 Based on record review and interview, the facility failed to: 1. Keep food in the freezer with dates properly visible. 2. Document the temperature of the snack refrigerators on the East and [NAME] Unit. This failure could potentially affect all residents in the facility who eat food prepared in the kitchen (residents were identified by the census provided by the Administrator on 09/16/24). If the facility fails to adhere to safe food storage, residents could likely be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: Food storage A. On 09/20/24 at 11:20 AM, during an observation of the kitchen's walk-in freezer a bag of hash browns was opened with an erased date that was not visible. B. On 09/20/2024 at 11:22 AM, during an interview with the kitchen's District Manager, he confirmed the bag of hash browns was opened with erased date. He stated the dates should be readable on all packaged food. Refrigerator Temperatures C. Record review of the [NAME] Unit snack refrigerator's temperature log, revealed staff did not document the refrigerator temperatures for the following dates: 1. 09/01/24. 2. 09/06/24. 3. 09/07/24. 4. 09/08/24. 5. 09/11/24. 6. 09/12/24. 7. 09/13/24. 8. 09/14/24. 9. 09/15/24. (continued on next page)

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	325047	A. Building B. Wing	10/28/2024

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. 09/19/24. 11. 09/20/24. 12. 09/21/24. 13. 09/24/24. D. On 09/26/24 at 11:26 AM, during an interview, CMA #8 confirmed staff did not document the refrigerator temperatures each day. CMA #8 said that temptress should be done everyday. E. Record review of the East Unit snack refrigerator temperature log revealed staff did not documented the refrigerator temperatures for the following dates: 1. 09/01/24. 2. 09/02/24. 3. 09/03/24. 4. 09/04/24. 5. 09/07/24. 6. 09/08/24. 7. 09/09/24. 8. 09/12/24. 9. 09/13/24. 10. 09/16/24. 11. 09/17/24. 12. 09/18/24. 13. 09/19/24. 14. 09/20/24. 15. 09/21/24. 16. 09/22/24. 17. 09/23/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. 09/24/24. F. On 09/26/24 at 11:36 AM, during an interview, CMA #9 confirmed staff did not document the refrigerator temperatures each day. CMA #9 said that temperatures were supposed to be done by the night shift. G. On 09/26/24 at 11:44 AM, during an interview, the DON confirmed staff did not document the refrigerator temperature each day. The DON said staff should check the temperatures once a day. 50497

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41755 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #40) of 8 (R #14, R #16, R #29, R #40, R #118, R #123, R #292 and R #293) 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. Record review of R #40's Admission Record, no date, revealed the following: 1. R #40 was admitted to the facility on [DATE]. 2. R #40's diagnoses as follows: protein-calorie malnutrition (not consuming enough protein and calories to meet the body's needs), bipolar disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings), and major depressive disorder (mental health condition characterized by persistently low or depressed mood). B. Record review of R #40's physician's orders revealed: 1. Order date 08/12/24, Percutaneous Endoscopic Gastrotomy Tube (PEG tube; medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) care. Cleanse area with normal saline or wound wash, apply split gauze, and secure with tape one time a day. 2. Order date 07/11/24, aripiprazole (antipsychotic medicine that works by changing the effects of chemicals in the brain used to treat mental/mood disorders such as schizophrenia or bipolar disorder) Give 7.5 mg at bedtime for major depressive disorder. C. Record review of R #40's treatment administration record (TAR, spreadsheet where nurses initial to indicate the completion of a treatment), for August and September 2024, revealed the order for PEG tube care was not listed, and staff did not document that PEG tube care was completed. D. Record review of R #40's physician progress notes, for visit date 06/21/24, revealed the following: Diagnosis, assessment, and plan. Bipolar disorder. Patient without recent mania (condition of abnormally elevated mood, activity or behavior) or depressive episode. Continue aripiprazole. E. On 09/27/24 at 10:33 AM, during an interview the DON confirmed the following: 1. There was not documentation of R #40's PEG tube care. Staff entered the PEG tube care order incorrectly, and the order did not make it on to the TAR for nursing staff to document the completion of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The DON stated the Doctor that completed the visit for R #40 on 07/11/24 was not the resident's regular doctor. The DON stated she was unsure if the antipsychotic medication was for the resident's bipolar disorder which is normally treated with an antipsychotic medication rather than for major depression which is not normally treated with an antipsychotic. 3. The DON confirmed that the documentation for R #40's use of antipsychotic was not clear.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 34303 Based on interview, the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training to staff. This could affect all 127 residents in the facility (residents were identified by the resident matrix provided by the Administrator on 09/16/24). This deficient practice could likely result in staff being unable to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor the effectiveness of interventions. The findings are: A. On 09/26/24 at 12:58 pm, during an interview, the Administrator stated the facility did not have the QAPI training in place for staff. The Administrator stated they were in the process of implementing the QAPI training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 34303 Based on interview and record review, the facility failed include performance reviews as part of their 12 hours of annual training for 3 (CNA #34, CNA #35, and CNA #36) of 3 (CNA #34, CNA #35, and CNA #36) CNAs sampled for 12 hours of annual training. This deficient practice could likely result in staff being under trained and providing inadequate care. The findings are: A. Record review of CNA #34's training records revealed the record did not contain performance evaluations. B. Record review of CNA #35's training records revealed the record did not contain performance evaluations. C. Record review of CNA #36's training records revealed the record did not contain performance evaluations. D. On 09/26/24 at 2:05 pm, the Staff Development Coordinator confirmed that CNA #34, CNA #35, and CNA #36 had been working in the facility more than a year. E. On 09/26/24 at 2:28 pm, the DON confirmed the facility did the performance reviews but did not use them as part of the 12 hours of annual training.