STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325108	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Del Sol Center	2905 East Missouri Avenue Las Cruces, NM 88011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to promote and facilitate resident's right to choose, when the facility failed to:Allow residents to eat breakfast in the dining room for all 49 resident who eat in the dining room (residents were identified by the Resident Matrix provided by the Administrator on 03/09/26).Allow R #5 to continue to smoke after a new smoking agreement and procedure was implemented at the facility.This deficient practice could likely result in residents becoming depressed and anxious because their right to choose is not being honored. The findings are:Dining RoomA. On 03/09/26 at 11:28 am, during an interview, R #6 stated that on Saturday 03/07/26 residents could not eat in the dining room. R #6 stated that they were told there was not enough staff for residents to eat in the dining room because one of the CNAs called out. R #6 stated that the residents had to eat in their rooms. B. Record review of the employee timecards for 03/07/26 revealed three CNAs were working the day shift (6:00 am - 6:00 pm). C. On 03/09/26 at 3:14 pm, during an interview, the DON stated that the facility was supposed to have four CNAs, but they only had three. The DON confirmed that residents did have to eat in their room and not in the dining room. The DON stated that she found out about it in the afternoon of 03/07/26. The DON also confirmed that there was no reason for it have happened. Residents should have been able to eat breakfast in the dining room. R #5D. Record review of R #5's face sheet no date revealed he was admitted on [DATE]. E. On 03/10/26 at 3:06 pm, during an interview R #5 stated that his smoking privileges were taken away. R #5 stated that he has been on 1 to 1 care (a single caregiver is assigned to one individual) because staff said he was smoking in the bathroom. R #5 denies smoking in the bathroom. R #5 stated that he signed that smoking agreement and procedure after he was admitted . R #5 stated he wants to smoke. F. Record review of Smoking Agreement and Procedures dated 12/22/25 revealed the following: Failure to comply with designated location and times and other smoking rules could result in termination of smoking privileges.R #5's signature.Witnessed by Social Services. G. Record review of R #5's progress notes revealed the following:01/16/26 Roommate [name of roommate] said that [name of R #5] has been smoking in the bathroom.His smoking privileges are revoked.02/12/25 Notified [Name of the ombudsman], Ombudsman, that the resident was non-compliant with the smoking policy. The roommate reported [Name of R #5] was smoking in the bathroom and has been going in and out of the center daily. He is currently placed on 1:1 supervision. H. On 03/10/26 at 3:32 pm, during an interview, the Administrator confirmed the following:R #5 had his smoking privileges taken away because his roommate had said he was smoking in the bathroom.Staff never caught him but could smell him.R #5 also liked to keep his smoking materials and not hand them over to staff.R #5 has been on 1 to 1 care since for safety.The Administrator confirmed that the facility had started a new smoking agreement and procedure after R #5 was admitted .

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 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** Based on observation, interview, and record review the facility failed to have an accurate MDS assessment for 1 (R #4) of 3 (R #2, R #3, and R #4) resident sampled for foley catheters, when staff failed to accurately assess that R #4 did not have a foley catheter. This deficient practice could likely result in staff being unaware of the residents' needs. The findings are:A. Record review of R #4's face sheet no date revealed he was admitted on [DATE]. B. Record review of the admission MDS dated [DATE] revealed resident had a Foley catheter. C. On 03/09/26 at 2:15 pm, during an observation of R #4 revealed no foley catheter. D. On 03/09/26 at 2:28 pm, during an interview the Unit Manager (UM) confirmed R #4 did not have a foley catheter. The UM confirmed that R #4's MDS did have foley catheter marked in error.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide quality of care in accordance with professional standards of practice for 1 (R #1) of 3 (R #1, R #7, and R #8) residents sampled for hospitalization, when staff failed to send R #1 to the hospital for several hours after receiving an order to send her. This deficient practice could likely result in resident's condition worsening and cause impairment or death. The findings are:A. Record review of R #1's medical record revealed:R #1 was admitted on [DATE].R #1 was sent to the hospital on [DATE]. B. Record review of the facility's 5 day follow up report 01/22/26 revealed the following:On 01/14/26 at approximately 11:00 pm, R #1's provider orders that she go to the hospital due to her recent lab results.RN #1 failed to send out R #1 until after 6:30 am on 01/15/26.RN #1 stated that she did not send R #1 to the hospital because she was unable to print the documents for transfer to hospital.RN #1 and LPN #1 (the LPN working the nightshift with RN #1) received education and disciplinary action. C. On 03/10/26 at 11:53 am, during an attempted interview RN #1 did not answer the phone call. She did not return the phone call. D. On 03/10/26 at 11:59 am, during an interview LPN #1 stated that the printer had not been working for a little while at the beginning of the year. LPN #1 stated that he did not receive any education on transferring residents to hospital or disciplinary action. F. On 03/10/26 at 12:17 pm, during an interview the Unit Manger (UM) confirmed that on night of 01/14/26 R #1's provider ordered that she go to the hospital due to her recent lab results. When the UM arrived at the facility on the morning of 01/15/26, R #1 had not been sent to the hospital. The UM confirmed that they sent R #1 to the hospital at that time. The UM stated that they had given education and disciplinary action to RN #1 and LPN #1 about sending residents to the hospital. The UM stated that the education was verbal. G. On 03/10/26 at 4:31 pm, during an interview the UM confirmed she had reviewed RN #1's and LPN #1's personnel file and that no disciplinary action was actually given to RN #1 or LPN #1.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have medical record complete and accurate for 2 (R #2 and R #3) of 3 (R #2, R #3, and R #4) resident sampled for foley catheters, when staff failed to have physician's orders for R #2's and R #3's foley catheters. This deficient practice could likely result in staff being unaware of the residents' needs and foley catheter care not being performed. The findings are:A. Record review of R #2's face sheet no date revealed she was admitted on [DATE]. B. Record review of R #2's care plan dated 03/03/26 revealed R #2 had a foley catheter. C. Record review of R #2's physician's orders no date revealed staff did not document an order for R #2's foley catheter. D. Record review of R #3's face sheet no date revealed he was admitted on [DATE]. E. Record review of R #3's care plan dated 02/09/26 revealed R #2 had a foley catheter. F. Record review of R #3's physician's orders no date revealed staff did not document an order for R #3's foley catheter. G. On 03/09/26 at 2:28 pm, during an interview, the Unit Manager (UM) confirmed staff did not document an order for foley catheters for R #2 and R #3. The UM confirmed that staff should have entered the order into R #2 and R #3 medical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow proper infection control practices for 1 (R #2) of 3 (R #2, R #3, and R #4) resident sampled for foley catheters, when staff failed to place signs and PPE (protective clothing, helmets, goggles, or other garments/equipment designed to protect from injury or infection) for R #2's enhanced barrier precautions (an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents). This deficient practice could likely result in residents who are susceptible to infection being exposed to staff and visitors who are not wearing the proper PPE increasing the risk of infections. The findings are:A. Record review of R #2's face sheet no date revealed she was admitted on [DATE]. B. Record review of R #2's care plan dated 03/03/26 revealed R #2 had a foley catheter. C. On 03/09/26 at 2:15 pm, during an observation of R #2's room revealed staff did not have an enhanced barrier precaution sign or PPE for R #2. D. On 03/09/26 at 2:18 pm, during an interview, the Unit Manager (UM) confirmed that R #2 did not have the enhanced barrier precautions sign or PPE outside of her room. The UM stated that she expects staff to have both in place for R #2 because she had a foley catheter.