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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47510 Based on observation and interview, the facility failed to ensure a resident was treated with respect and dignity for 1 (R #23) of 1 (R #23) resident when the staff failed to sit next to the resident while assisting them to eat. This deficient practice could likely result in residents feeling embarrassed, angry, and that their feelings are unimportant to the facility staff. The findings are: A. On 03/10/25 at 12:11 PM, during an observation of lunch, CNA #9 assisted R #23 with eating his lunch. CNA #9 stood over R #23. CNA #9 was not sitting down beside R #23 while she fed him. CNA #9 left the dining area and asked CNA #16 to assist R #23 with his lunch. CNA #16 stood over the resident to feed him also. B. On 03/13/25 at 8:56 AM, during an interview, CNA #16 confirmed that she did assist R #23 during lunch on 03/10/25. CNA #16 confirmed she stood over R #23. CNA #16 said they are supposed to be sitting down next to the resident, but the dining area was so crowded that she ended up standing instead of sitting down next to the resident. C. On 03/13/25 at 9:32 AM, during an interview, CNA #9 confirmed that she assisted R #23 while eating lunch on 03/10/25. CNA #9 said she usually sits down beside R #23, but if she can't find a chair, she will stand to feed him. D. On 03/17/25 at 2:41 PM, during an interview, the DON said her expectation is that when R #23 is being assisted with meals staff should sit down with the resident at eye level.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41755 Based on observation and interview, the facility failed to provide a homelike environment that was in good condition for 1 (R #18) of 1 (R #18) resident reviewed for a homelike environment by not repairing the trimming on the windowsill in R #18's room. Failure to maintain and provide a comfortable environment is likely to result in residents feeling unimportant and undervalued. The findings are: A. On 03/12/25 at 9:34 AM, during an interview with R #18 she pointed to her windowsill which had areas of trimming that were broken off. R #18 stated trimming on her windowsill had been broken off for months but could not remember exactly how long. B. On 03/12/25 at 9:34 AM, an observation of R #18's revealed a section of the trimming on the windowsill was broken off near R #18's bed. C. On 03/14/25 at 3:03 PM, during an interview with the Maintenance Director, he confirmed R #18's windowsill trim was broken and needed to be replaced again. The Maintenance director stated it had been replaced in the past because it has been broken due to R #18's bed being moved up and down and scraping the windowsill trimming off.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review and interview, the facility failed to ensure a comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was completed within 14 calendar days after admission for 1 (R #162) of 4 (R #13, R #17, R #60 and R #162) residents reviewed. This deficient practice could likely result in residents' preferences and care needs not being met. The findings are: A. Record review of R #162's Admission record revealed an admitted [DATE]. B. Record review of R #162's Admission MDS assessment revealed the Admission MDS assessment was completed on 01/21/25. C. On 03/21/25 at 9:43 AM, during an interview with the MDS Coordinator, she confirmed R #162's Admission MDS assessment was not completed within 14 days of admission. The MDS Coordinator confirmed that the Admission MDS assessments should be completed within 14 days of admission.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to complete and transmit (electronically sending encoded information) a Significant Change (major decline or improvement in the patient's health status) Minimum Data Set assessment within 14 days after the facility determined a significant change in the resident's physical or mental condition for 1 (R #32) of 1 (R #32) resident reviewed for MDS assessment timing. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are: A. Record review of R #32's nursing progress note dated 11/13/24 revealed R #32 was admitted to hospice. B. Record review of R #32's change of condition MDS assessment dated [DATE], revealed the MDS assessment was not completed and signed off by the Registered Nurse (RN) until 12/19/24. C. On 03/17/25 at 2:08 PM, during an interview with the MDS Coordinator, she confirmed R #32's was admitted to hospice on 11/13/24 and that the Significant change MDS assessment for R #32 was not completed within 14 days of hospice admission.

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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; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) was accurate for 3 (R #13, R #17, and R #60) of 7 (R #7, R #8, R #13, R #17, R #18, R #20 and R #60) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are:

R#13

A. Record review of R #13's admission record revealed R #13 was admitted to the facility on [DATE].

B. Record review of R #13's physician's orders revealed the following:

1. An order, dated 03/21/23, pregabalin (nerve pain medication) capsule 150 mg give 1 capsule by mouth two times a day for neuropathy (damage, disease, or dysfunction of one or more nerves which can cause burning or shooting pain, numbness and/or tingling)

2. An order, dated 12/16/22, for clopidogrel (antiplatelet medication that reduces the chance that a harmful blood clot will form by preventing platelets from clumping together in the blood) 75 mg give 1 tablet by mouth every Monday, Wednesday, and Friday.

C. Record review of R #13's Annual MDS, dated [DATE], revealed the following:

1. Section J0100: Pain Management

a. Staff documented that R #13 did not receive scheduled pain medication.

2. Section N0415: High-Risk Drug Classes: Use and Indication.

a. Staff documented that R #17 was taking an antiplatelet.

D. On 03/17/25 at 2:13 PM, during an interview with the MDS coordinator, she confirmed the following:

1. R#13 did take scheduled pregabalin medication to treat neuropathy (nerve pain) and staff inaccurately documented that R #13 did not receive scheduled pain medication on R #13's Annual MDS, dated [DATE].

2. Clopidogrel is an antiplatelet medication and should not be coded as an anticoagulant medication.

3. Staff inaccurately documented that R #13 was taking an anticoagulant on R #13's Annual MDS, dated [DATE].

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R#17 E. Record review of R #17's admission record revealed R #4 was admitted on [DATE]. F. Record review of R #17's medical record, no date, revealed R #17 had a diagnosis of Pneumonitis (selling and irritation of lung tissue, which can lead to lung damage if left untreated) due to inhalation of food and vomit with an onset date of 12/30/23. G. Record review of R #17's physician's orders, multiple dates, revealed the following: 1. An order, dated 03/08/24, for Levaquin (antibiotic that treats bacterial infections) 500 Mg every morning for Pneumonitis due to inhalation of food and vomit for 5 days. 2. An order, dated 05/19/24, for Paxlovid (Paxlovid is an antiviral medication used to treat COVID-19 (an infectious disease caused by the SARS-CoV-2 virus)) twice a day for 5 days due to COVID-19. 3. An order, dated 12/29/23, for Clopidogrel Bisulfate (a platelet inhibitor that reduces the chance that a harmful blood clot will form by preventing platelets from clumping together in the blood) 75 mg to be taken daily for blood clot prevention. H. Record review of R #17's Quarterly MDS, dated [DATE], revealed the following: 1. The Assessment Reference End Date was 01/20/25. 2. Section I: Active Diagnoses Active Diagnoses in the last 7 days-Check all that apply. a. Staff checked Pneumonia. 3. Section N0415: High-Risk Drug Classes: Use and Indication. a. Staff documented that R #17 was taking an anticoagulant. b. Staff documented that R #17 was taking an antiplatelet. I. Record review of the entire medical record, no date, revealed the following: 1. The medical record did not contain documentation that R #17 had pneumonia in the 7 days prior to the MDS Assessment Reference End Date (01/20/25). 2. The medical record did not contain documentation that R #17 was taking an anticoagulant. J. On 03/17/25 at 1:51 PM, during an interview with the MDS coordinator, she confirmed the following: 1. R#17 did not have pneumonia within 7 days prior to the MDS Assessment Reference End Date (01/20/25). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Staff inaccurately documented the diagnosis of Pneumonia on R #17's Quarterly MDS, dated [DATE]. K. On 03/17/25 at 1:53 PM, during an interview with the Unit Manager, she confirmed the following: 1. R #17 did not have orders for anticoagulant medication. 2. Clopidogrel is an antiplatelet medication and should not be coded as an anticoagulant medication. 3. Staff inaccurately documented that R #17 was taking an anticoagulant on R #17's Quarterly MDS, dated [DATE]. R #60 L. Record review of R #60's admission record revealed R #60 was admitted on [DATE]. M. Record review of R #60's discharge MDS dated [DATE], revealed R #60 was discharged on [DATE] to a short-term general hospital. N. Record review of R #60's discharge plan dated 02/11/25, revealed R #60 was discharged home to Pennsylvania with R #60's daughter. O. On 03/14/25 at 10:15 AM, during an interview, the Unit Manager (UM) said that R #60 was at the facility for a short time and R #60's daughter decided it was best to take her home to Pennsylvania. The UM stated that R #60 was discharged home with her daughter. P. On 03/14/25 at 2:58, during an interview, the DON confirmed that the resident was discharged home and not to a hospital. The DON said that her expectation is that the documentation be accurate. 47510 49313

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49313 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 1 (R #56) of 3 (R #15, R #49, and R #56) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: A. Record review of R #56's admission record (no date) revealed the following: 1. R #56 was admitted to the facility on [DATE]. 2. Diagnoses: a. Traumatic subdural hemorrhage without loss of consciousness (bleeding between the brain and the dura mater (the outermost layer of tissue covering the brain) caused by a head injury, where the person remains alert and conscious). b. Acute Embolism and Thrombosis of Right Axillary Vein (a type of deep vein thrombosis (DVT, blood clot) that specifically affects the axillary vein, located in the armpit) c. Thrombocytopenia (abnormally low number of platelets in the blood. Platelets are small blood cells that play a crucial role in blood clotting). d. Neuromuscular dysfunction of bladder a condition where bladder control is impaired due to damage to the nerves or brain that control bladder function). B. Record review of R #56's orders, multiple dates, revealed the following: 1. Order dated 02/19/25 for foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) change every month on the 17th for neurogenic bladder (bladder dysfunction caused by nervous system conditions). 2. Order dated 02/25/25, for Lasix (antidiuretic medication used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions) 40 mg twice a day for fluid retention (an accumulation of fluid in body tissues and cavities). 3. Order dated 02/25/25, for Eliquis (an anticoagulant medication used to treat and prevent blood clots and to prevent stroke in people with nonvalvular atrial fibrillation) 5 mg twice a day for cerebrovascular accident (CVA, commonly known as a stroke, is a medical condition where blood flow to the brain is interrupted, leading to brain damage and potential neurological problems). B. Record review of R #56's Admission Minimum Data Set (MDS, federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes) Assessment, dated 02/26/25, revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Section H- Bladder and Bowel: H0100 Appliances; Staff selected Indwelling catheter (foley catheter). 2. Section N- Medications: N0415 High-Risk Drug Classes; Staff selected anticoagulant and diuretic. C. Record review of R #56's care plan, dated 02/21/25, revealed staff did not document the following: 1. R #56's had a foley catheter for neurogenic bladder. 2. R #56 had an order for the high-risk medication Eliquis for CVA. 3. R #56 had an order for the high-risk medication Lasix for fluid retention. D. On 03/13/25 at 9:52 AM, during an interview with RN #16, she confirmed the following: 1. R #56 had a foley catheter. 2. R #56's care plan did not include that she had a foley catheter or interventions in place to care for R #56's foley catheter. E. On 03/17/25 at 1:45 PM, during an interview with the MDS coordinator, she confirmed the following: 1. R #56's admission MDS dated [DATE] indicated that R #56 had a foley catheter. 2. R #56's comprehensive care plan should have included R #56's foley catheter and interventions in place to care for the foley catheter. F. On 03/17/25 at 2:06 PM, during an interview with the Unit Manager (UM), she confirmed the following: 1. R #56 had an order for Eliquis, which is a high-risk medication. 2. R #56 had an order for Lasix, which is a high-risk medication. 3. R #56's care plan did not include that she was taking Eliquis or Lasix. 4. High-risk medications should be included on resident care plans.

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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 Based on record review and interview, the facility failed to ensure care plan requirements were met for 6 (R #8, R #15, R #18, R #49, R #56, and R #162) of 10 (R #7, R #8, R #13, R #15, R #18, R #20, R #32, R #49, R #56, and R #162) residents reviewed for care plans when staff 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 #15 and R #49. 2. Ensure the care plan meeting was held after the completion of the admission Minimum Data Set Assessment (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) when creating the care plan for R #8, R #15, R #18, R #49, R #56, and R #162. 3. Revise the care plan with the most current resident information for R #56. 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 #15 A. Record review of R #15's care plan meeting notes, dated 12/09/24, revealed the individuals that were present at the meeting were: R #15's family member, the Unit Manager (UM), the Social Services Worker (SSW), and the Medical Records Clerk (MRC). R #49 B. Record review of R #49's care plan meeting note, dated 10/15/24, revealed the individuals that were present at the meeting were: R #49, the UM and the SSW. Timing R #8 C. On 03/10/25 at 3:02 PM, during an interview with R #8, she stated she had not participated in a care plan meeting since she was admitted to the facility on [DATE]. D. Record review of R #8's Admission MDS, dated [DATE], revealed the assessment was signed by the Registered Nurse (RN) on 02/21/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. She stated the individuals who are invited to care plan meetings include the resident and their representatives, the UM, therapy, activities, SSW, Infection prevention if needed, and the MDS nurse. 2. She confirmed that a CNA with responsibility for the resident is not typically invited to the care plan meeting. 3. She confirmed that the provider is not typically invited to the care plan meeting. 4. R #15's last care plan meeting was held on 12/09/25. 5. R #49's last care plan meeting was held on 10/15/25. 6. The facility did not complete an IDT care plan meeting for R #56 since she arrived on 02/19/25. BB. On 03/18/25 at 8:33 AM, during an interview with SSW, he confirmed the following: 1. He was responsible for scheduling care plan meetings. 2. He does not typically invite the provider or CNA's. 3. He stated that he has been behind scheduling care plan meetings. 47510 49313

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49313 Based on record reviews, and interviews, the facility failed to meet professional standards of quality for 1 (R #49) of 1 (R #49) residents when staff failed to administer medications according to physician's orders. If the facility is not providing care that meets professional standards of quality, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: A. Record review of R #49's admission record, no date, revealed R #49 was admitted to the facility 06/11/24. B. Record review of R #49's physician order, dated 12/06/25, for Renvela (is used to control phosphorus levels in adults with chronic kidney disease) 800 mg three times a day with meals for end stage renal disease (ESRD, a condition in which the kidneys lose the ability to remove waste and balance fluids). C. Record review of R #49's medication administration record (MAR; a form used to document medication administration), dated March 2025, revealed staff documented the following: 1. On 03/10/25 at 700 AM, renvela, staff documented not administered, see nurses note (NN). 2. On 03/10/25 at 12:30 AM, renvela, staff documented NN. 3. On 03/10/25 at 12:30 AM, renvela, staff documented NN. 4. On 03/11/25 at 700 AM, renvela, staff documented NN. D. Record review of R #49's progress notes for March 2025, revealed staff documented the following for R #49's renvela medication: 1. On 03/10/25 at 8:03 AM, awaiting on med from pharmacy. 2. On 03/10/25 at 12:13, awaiting med from pharmacy. 3. On 03/11/25 at 7:23 AM, awaiting med from pharmacy. 4. On 03/11/25 at 1:09 PM, awaiting med from pharmacy. E. On 03/14/25 at 10:11 AM, during an interview with CMA #16, she stated the following: 1. When medications get to the last 7 doses, the medication aids or nurses are expected to reorder the medication in the electronic medical record (EMR). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. She confirmed that R #49 did not receive her renvela on 03/10/25 and 03/11/25 due to the medication being unavailable. 3. She stated that she notified the Unit Manager (UM) on 03/10/25 that R #49's renvela had not arrived from the pharmacy. F. Record review of R #49's order summary for renvela, dated 03/14/25, revealed staff reordered R #49's renvela on 03/10/25 and it was received on 03/11/25. G. Record review of the electronic shipping manifest, dated 03/11/25, revealed R #49's renvela was received by the facility on 03/11/25 at 11:06 PM. H. On 03/17/25 at 2:14 PM, during an interview with the UM, she confirmed the following: 1. Staff are expected to reorder medication when there are 9 pills left. 2. Staff did not reorder R #49's renvela until 03/10/25.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review and interview, the facility failed to provide activities of daily living (ADL) assistance for 1 (R #23) of 1 (R #23) residents reviewed for ADL care when staff failed to assist R #23 with brushing his teeth at night. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. On 03/11/25 at 11:02 AM, during an interview, R #23's sister said R #23 doesn't get his teeth brushed on a regular basis. B. Record review of R #23's Quarterly Minimum Data Set (MDS) dated [DATE] revealed R #23 required assistance is dependent for ADL care. C. On 03/12/25 at 3:23 PM, during an interview, CNA #8 said she sometimes brushes R #23's teeth at night if it is needed. CNA #8 said she usually rinses R #8 mouth out but she doesn't brush his teeth regularly. CNA #8 said that the morning shift usually brushes the resident's teeth. D. Record review of R #23's ADL sheet, dated February 2025, revealed that oral care is not being documented. E. On 03/12/25 at 3:39 PM, during an interview, the Unit Manager (UM) said R #23's teeth should be brushed twice a day. The UM said confirmed that the documentation does not show if R #23 is getting his teeth brushed twice a day or not. F. On 03/13/25 at 9:47 AM, during an interview, the DON said the expectation is that resident's teeth get brushed at least twice a day and that it be documented when it is done. G. Record review of the facility's oral health policy dated 09/01/25 revealed that oral hygiene will be performed, at a minimum, two times a day. Oral hygiene should be done to maintain the mouth in a clean and intact condition and to prevent or reduce systemic diseases (conditions that affect multiple organs or systems in the body).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure wound care orders were obtained and implemented timely for 1 (R #7) of 5 (R #1, R #7, R #34, R #35 and R #49) residents reviewed for pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time), when staff failed to: 1. Have wound care orders obtained and implemented for R #7's pressure wound on the sacrum (area of spinal column just above the coccyx) for 2 days after R #7 was admitted . 2. Have wound care orders obtained and implemented for R #7's pressure wounds on the Left and Right heel for 3 days after being admitted . These deficient could likely result in the provider being unaware of the resident's current condition, leading to inconsistent interventions and worsening of pressure ulcers. The findings are: A. Record review of R #7's admission record (no date) revealed R #7 was admitted to the facility on [DATE]. B. Record review of R #7's Convalescent Care Orders (admission orders provided to the nursing home) dated 01/07/25 revealed the following: Does the patient have any wounds? Yes C. Record review of R #7's Clinical Admission, dated 01/08/25 revealed the following: 1. Skin: a. left heel pressure ulcer present on admission. b. right heel pressure ulcer present on admission. c. sacrum pressure ulcer present on admission. D. Record review of R #7's Dietitian assessment note dated 01/10/25 revealed the following: 1. R #7 has pressure ulcers to sacrum and bilateral heels. 2. R #7 is at nutritional risk due to skin breakdown. E. Record review of R #7's Nursing Progress Notes dated 01/08/25 through 01/09/25 revealed staff did not consult with the facility provider to obtain wound care orders. F. Record review of R #7's physician's orders revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. An order dated 01/10/25, Sacrum wound- clean with normal saline (saltwater solution used to cleanse), pat dry, apply Santyl (enzyme ointment used to treat skin ulcers by helping to remove dead skin tissue and aid in wound healing) nickel thick (thickness of a nickel approximately 2 millimeters) to wound bed, cover with 4x4 (gauze dressing that measures 4 inches by 4 inches), moistened with Dakin's (diluted bleach solution used in wound treatment to prevent and treat skin and tissue infections), 4x4 and Meditape (medical-grade cotton with strong adhesiveness that is primarily used to secure dressings) every day shift for wound care. 2. An order dated 01/11/25, Bilateral heels clean with normal saline, pat with iodine (antiseptic solution use to keep area dry and skin intact) moistened gauze, do not cover (open to the air) every day shift. G. Record review of R #7's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed) for January 2025 revealed the following; 1. Facility staff did not have orders in place for treatment of R #7's sacrum pressure ulcer until 01/10/25 (two days after admission). 2. Facility staff did not have orders in place for treatment of R #7's left and right heel pressure ulcers until 01/11/25 (three days after admission). H. On 01/30/25 at 4:12 PM, during an interview, the facility wound care nurse, stated the following: 1. Nursing staff completing the admission should contact the provider to obtain wound care orders. 2. Nursing staff did not obtain orders for R #7's pressure ulcers which were present on admission. 3. It is her expectation that orders be obtained on admission if residents are admitted with pressure ulcers.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to effectively (use of different techniques and medication to reduce and control the amount of pain a person experiences) manage pain for 1 (R #13) of 2 (R #13 and R #46) residents reviewed for pain when the facility failed to implement orders for treatment of pain for 17 days after R #13's appointment with her provider. This deficient practice could likely result in residents experiencing unnecessary pain. The findings are: A. On 03/10/25 at 3:31 PM, during an interview, R #13 stated she is always in pain. R #13 stated she has had pain in her nose and tongue for several months. B. Record review of R #13's admission record revealed R #13 was admitted to the facility on [DATE]. C. Record review of R #13's Ear, Nose and Throat (ENT) Institute (specialist in the treatment of the ears, nose, throat, sinuses, head and neck) provider progress note, dated 01/29/25, revealed the following: 1. Chief complaint: Patient is here for pain in her nose and throat. Pain is daily. 2. R #13 had a diagnosis of atypical facial pain (chronic, constant pain in the absence of any apparent cause in the face or brain). 3. Assessment/plan: Start R #13 on amitriptyline (antidepressant medication often used to help treat chronic pain) 10 mg and increase by 10 mg each week until she reaches a dose of 50 mg daily. D. Record review of R #13's physician orders revealed an order start date 02/14/25, amitriptyline 10 mg give 1 tablet by mouth one time a day. E. Record review of R #13's Medication Administration Record (MAR; the form used to document medication administration), dated February 2025, revealed R #13 received her first dose of amitriptyline on 02/14/25. F. On 03/17/25 4:09 PM, during an interview with the unit manager and DON they confirmed that there was a delay in starting the amitriptyline prescribed by the ENT provider at R #13's visit on 01/29/25 and R #13 received her first dose of the medication sixteen (16) days after her appointment.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure residents have a written, signed, and dated progress notes at each visit from the provider (physician or nurse practitioner) for 1 (R #7) of 1 (R #7) resident reviewed for physician's visits, when they failed to have R #7's provider: 1. Sign their progress notes at the time of the visit. 2. Provide their progress note at the time of the visit. This deficient practice could likely result in the residents' needs not being met due to facility not having written, signed, and dated progress notes from the provider. A. Record review of R #7's admission record (no date) revealed R #4 was admitted to the facility on [DATE]. B. On 03/13/25 at 10:06 AM, during an interview with Medical Records staff, she confirmed there were no wound care consultation progress notes scanned into R #7's medical record. C. Record review of R #7's wound care consultant (outside provider coming to facility to provide wound care treatment) progress notes revealed: 1. Nurse Practitioner (NP) note: visit date 02/06/25. The NP did not electronically sign the note until 02/09/25 and the note was not sent to the facility until 02/20/25. 2. NP note: visit date 02/20/25. The NP did not electronically sign the note until 02/22/25 and the note was not sent to the facility until 03/14/25. 3. NP note: visit date 02/27/25. The NP did electronically sign the note on 02/27/25, but the note was not sent to the facility until 03/14/25. 4. NP note: visit date 03/06/25. The NP did electronically sign the note on 03/06/25, but the note was not sent to the facility until 03/14/25. 5. NP note: visit date 03/13/25. The NP did not electronically sign the note until 03/14/25 and the note was not sent to the facility until 03/14/25. D. On 03/17/25 at 3:31 PM, during an interview with the facility wound care nurse, she stated she completed resident rounds (visits to assess wounds) with the wound care consultant. The wound care consultant then provides her with verbal orders for wound care. The wound care nurse confirmed that they do not get the wound care consultant progress notes on the day of the visit.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47510 Based on interview and record review, the facility failed to ensure the CNA's are able to demonstrate competency in skills and techniques necessary to care for residents' needs for 3 (CNA #8, CNA #9, and CNA #16) of 3 (CNA #8, CNA #9, and CNA #16) CNAs reviewed for competent nursing staff, when they failed to: 1. Have a competency evaluation (the facility's way to measure an individual's knowledge and skills as related to safe, competent performance through demonstration of those skills) for CNA #8, CNA #9, and CNA #16 at the time of hire before they start to work with residents. 2. Have a competency evaluation for CNA #8, CNA #9, and CNA #16 routinely after hire. These deficient practices could likely result in CNA's working with residents without adequate knowledge to do so; likely resulting in injury or inappropriate care being provided to the residents. The findings are: A. Record review of CNA #8's personnel files revealed the following: 1. CNA #8 was hired on 12/03/24. 2. Staff did not document that a competency evaluation was completed for CNA #8 demonstrating their knowledge, ability, and skills to care for residents. B. Record review of CNA #9's personnel files revealed the following: 1. CNA #9 was hired on 11/14/18. 2. Staff did not document that a competency evaluation was completed for CNA #9 demonstrating their knowledge, ability, and skills to care for residents. C. Record review of CNA #16's personnel files revealed the following: 1. CNA #16 was hired on 02/25/19. 2. Staff did not document that a competency evaluation was completed for CNA #16 demonstrating their knowledge, ability, and skills to care for residents. D. On 03/14/25 at 3:51 PM, during an interview, the Nurse Practice Educator (NPE) confirmed CNA #8, CNA #9, and CNA #16 did not have a competency evaluation. E. On 03/17/25 at 2:48 PM, during an interview, the DON said that competency evaluations should be carried out before staff start working the floor. The DON said that staff should have an onboarding competency evaluation to demonstrate that they are proficient in resident care before they start providing resident care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47510 Based on interview and record review, the facility failed to complete performance reviews at least every 12 months for 2 (CNA #10 and CNA #16) of 3 (CNA #8, CNA #10, and CNA #16) CNAs sampled for 12 hours of annual training. This deficient practice could likely result in staff being undertrained and providing inadequate care. The findings are: A. Record review of the employee files revealed the following: 1. CNA #10's hire date was 11/14/2018 2. There are no performance evaluations for CNA #10. 3. CNA #16's hire date was 02/25/2019. 4. There are no performance evaluations for CNA #16. B. On 03/17/25 at 3:51 PM, during an interview, the Nurse Practice Educator (NPE) confirmed that there were not any performance evaluations for CNA #10, and CNA #11.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 staff failed to: 1. Dispose of a loose tablet stored in the medication chart for the D Unit. 2. Ensure open medication had an open date for B Unit Medication Cart 3. Document temperatures for the medication refrigerators. This could affect all 57 residents in the facility (Residents were identified by the resident matrix provided by the Administrator on 03/10/25). 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: A. On 03/17/25 at 2:02 PM, during an observation of the B Unit Medication Cart revealed the following: 1. Lactulose solution 10 g was open and did not have an open date. 2. Enulose 10 g was open and did not have an open date. B. On 03/17/25 at 2:02 PM, during an observation of the D Unit Medication Cart revealed the following: 1. One loose white round tablet with no markings in the medication cart. 2. Lactulose solution 10 g open and did not have an open date. C. On 03/17/25 at 2:14 PM, during an observation of the medication storage room revealed the following: 1. The black medication refrigerator had insulin, gabapentin 250 mg, and suppositories. 2. The white locked medication refrigerator had bisacodly suppositories, morphine, and flu vaccines. D. Record review of the temperature logs of the medication refrigerator revealed the following: 1. Staff did not document temperatures on the black medication refrigerator on 03/15/25, 03/16/25, and 03/17/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Staff did not document temperatures on the white locked medication refrigerator on 03/15/25, 03/16/25, and 03/17/25. E. On 03/17/25 at 2:23 PM, during an interview, CMA #8 confirmed the open medications in both Unit B and D medication cart did not have open dates. CMA # 8 confirmed there was a loose pill in the D Unit medication cart. CMA #8 further confirmed that the temperatures for the medication refrigerator had not been documented that they were checked since 03/14/25. F. On 03/17/25 at 2:38, during an interview, the DON said that medication should be dated with the open date once they are open. The DON confirmed there should not be any loose pills in the med carts. The DON said the refrigerator temperatures should be checked and documented every shift. The DON said that the medication in the refrigerators could be out of temperature range and spoil if they aren't checked.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview the facility failed to ensure residents obtained dental services for 2 (R #18 and R #23) of 3 (R #18, R #23 and R #46) residents sampled for dental services, when they failed to ensure residents receive routine dental care to include an annual inspection of the mouth for signs of disease, dental cleaning, fillings, or minor partial or full denture adjustments. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition/appearance of teeth, and potential dental or oral complications. The findings are: R #18 A. On 03/12/25 at 9:32 AM, during an interview, R #18 stated one of her teeth fell out approximately a week ago and she has not been to the dentist since her admission to the facility. B. Record review of R #18's Admission Record, no date, revealed an admitted [DATE]. C. Record review of R #18's physician's order dated 11/03/23 revealed dental, obtain consult as needed/indicated and treatment for patient health and comfort. D. On 03/17/25 at 11:58 AM, during an interview with Medical Records staff, she confirmed R #18 had not been seen by a dentist since her admission. R #23 E. Record review of R #23's medical record revealed an admitted [DATE]. F. On 03/11/25 at 11:02 AM, during an interview, R #23's sister said staff don't brush R #23's teeth on a regular basis and R #23 has not been to the dentist since his admission to the facility. G. Record review of R #23's physician's order dated 09/06/24 revealed dental as needed/indicated and treatment for patient health and comfort. H. On 03/13/25 at 10:06 AM, during an interview, the Records Manger (RM) stated R #23 had not seen a dentist for routine dental care since his admitted [DATE]. The RM said if the resident asks to see a dentist that she will make an appointment. She said if the resident is not able to tell her they need an appointment, she leaves it up to the family to decide if the resident needs care. 47510

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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. 49313 Based on observation and interview, the facility failed to serve food under sanitary conditions by professional standards of food service safety for 4 (R #15, R #23, R #42, and R #54) of 4 (R #15, R #23, R #42, and R #54) residents when staff failed to perform hand hygiene prior to assisting residents with eating and drinking. If the facility fails to adhere to safe food handling practices and hygiene practices, residents could likely be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On 03/10/25 at 12:17 PM, during an observation of the dining room the following was revealed: 1. CNA #16 assisted R #42 with eating and drinking. 2. CNA #16 assisted R #15 with cutting her sandwich, she did not perform hand hygiene prior to assisting R #15. 3. CNA #16 returned to assist R #42 with eating and drinking, she did not perform hand hygiene prior to returning to assist R #42. 4. CNA #16 returned to assist R #15 with placing her drink closer to R #15, she did not perform hand hygiene prior to assisting R #15. 5. CNA #16 returned to assist R #42 with eating and drinking, she did not perform hand hygiene prior to returning to assist R #42. 6. CNA #16 assisted R #54 with moving her food on her plate using R #54's fork, she did not perform hand hygiene prior to assisting R #54. 7. CNA #16 returned to assist R #42 with eating and drinking, she did not perform hand hygiene prior to returning to assist R #42. 8. CNA #16 got a refill for R #38's drink, then performed hand hygiene. 9. CNA #16 returned to assist R #42 with eating and drinking. 10. CNA #16 returned to assist R #15 placing R #15's bag of chips closer to her and cutting R #15's sandwich, she did not perform hand hygiene prior to assisting R #15. 11. CNA #16 returned to assist R #54 with eating and drinking, she did not perform hand hygiene prior to assisting R #54. 12. CNA #16 returned to assist R #15 with cutting her sandwich, she did not perform hand hygiene prior to assisting R #15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER Casa Del Sol Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2905 East Missouri Avenue Las Cruces, NM 88011	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. CNA #16 touched R #20's wheelchair. 14. CNA #16 assisted R #23 with eating and drinking, she did not perform hand hygiene prior to assisting R #23. B. On 03/10/25 at 1:10 PM, during an interview with CNA #16, she stated the following: 1. She did not perform hand hygiene prior to assisting each resident with eating and drinking. 2. She performed hand hygiene two times during the lunch meal. 3. She was supposed to perform hand hygiene prior to assisting each resident. C. On 03/10/25 at 1:11 PM, during an interview with the infection control nurse, he confirmed staff were expected to perform hand hygiene prior to assisting each resident with eating and drinking.

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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** 49313 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #56) of 2 (R #15 and R #56) 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 #56's admission record (no date) revealed the following: 1. R #56 was admitted to the facility on [DATE]. 2. Diagnoses: a. Traumatic subdural hemorrhage without loss of consciousness (bleeding between the brain and the dura mater (the outermost layer of tissue covering the brain) caused by a head injury, where the person remains alert and conscious). b. Acute Embolism and Thrombosis of Right Axillary Vein (a type of deep vein thrombosis (DVT, blood clot) that specifically affects the axillary vein, located in the armpit) c. Thrombocytopenia (abnormally low number of platelets in the blood. Platelets are small blood cells that play a crucial role in blood clotting). B. Record review of R #56's physician order, dated 02/25/25, revealed an order for Eliquis (an anticoagulant medication used to treat and prevent blood clots and to prevent stroke in people with nonvalvular atrial fibrillation) 5 mg twice a day for cerebrovascular accident (CVA, commonly known as a stroke, is a medical condition where blood flow to the brain is interrupted, leading to brain damage and potential neurological problems). C. Record review of R #56's entire medical record, no date, revealed staff did not document monitoring of resident for the use of anticoagulants. D. On 03/13/25 at 9:52 AM, during an interview with RN #16, she stated the following: 1. CNA's monitor R #16 for blood in stool or urine. 2. She stated the nurses document monitoring for bleeding for all residents that are taking anticoagulants in the electronic medical record. 3. She confirmed staff had not documented that R #56 was being monitored for bleeding since she arrived on 02/19/25. E. On 03/17/25 at 2:08 PM, during an interview with the Unit Manager, she confirmed the following: 1. All residents who take an anticoagulant should be monitored for bleeding. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Staff are expected to document that the resident's are being monitored for bleeding in the electronic medical record. 3. Staff did not document that R #56 was being monitored for bleeding between 02/19/25 and 03/13/25.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 47510 Based on observation and interview, the facility failed to provide sufficient space for dining. This failure has the potential to affect all 57 (as listed on the Resident Census provided by the Administrator on 03/10/25) and could likely hinder safe movements and disrupt residents dining experience. The findings are: A. On 03/10/25 at 12:11 pm, during lunch, the following observation was made: 1. The dining area was very crowded with residents' wheelchairs and walkers, making moving around difficult to include serving and assisting the residents with dining, and exiting the area after the meal was complete. 2. A resident was trying to get to a table and his wheelchair wheels got caught up on another resident's wheelchair wheels. 3. Staff were assisting residents with eating while standing up beside them. B. On 03/13/25 at 12:26 pm, during lunch, the following observation was made: 1. The dining area was crowded with residents. 2. One resident had a difficult time leaving the area after he finished eating. 3. Staff were assisting a resident in a Geri chair (a large, padded chair that is designed to help seniors with limited mobility). Staff had to move several residents away from the table to try to get the residents through. Staff had to choose another way out and had to move a tray with drinks to get him out of the dining area. C. On 03/13/25 at 8:56 AM, during an interview, CNA #16 confirmed she did assist R #23 during lunch on 03/10/25. CNA #16 confirmed that she was standing over R #23. CNA #16 said that they are supposed to be sitting down next to the resident but that the dining area is so crowded that she ends up standing instead of sitting down next to the resident. D. On 03/13/25 at 9:32 AM, during an interview, CNA #9 confirmed she assisted R #23 while eating lunch on 03/10/25. CNA #9 said she usually sits down beside R #23, but if she can't find a chair, and if it is too crowded, she will stand to feed him. E. On 03/17/25 at 2:41 PM, the DON said that the expectation during meals is that residents have an easier flow for getting in and out. The DON said that if resident's are being assisted, staff should sit and be at eye level so that they can assess them better. The DON said that they are in the process of freeing up some room to make it easier for residents and staff during mealtimes.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on record review and interview, the facility failed to provide behavioral health training (training that helps staff recognize and respond to various behavioral and mental health issues that residents may present with) for 1 (CNA #8) of 3 (CNA #8, CNA #10, and CNA #11) staff sampled for training. This deficient practice could likely result in residents not receiving the services necessary to attain or maintain their physical, mental, and psychosocial (involving both psychological and social aspects) well-being. The findings are: A. Record review of R #19's admission record, (no date) revealed that she was admitted to the facility on [DATE] with the diagnosis of Anxiety disorder, unspecified (condition where individuals experience anxiety-like symptoms that cause severe distress or impairment). B. Record review of R #23's admission record, (no date) revealed that he was admitted to the facility on [DATE] with the diagnosis of schizophrenia (chronic mental disorder characterized by disruptions in thought processes, perceptions, emotions, and social interactions). C. Record review of R #35's admission record, (no date) revealed that she was admitted to the facility on [DATE] with the diagnosis of dementia, unspecified severity, with anxiety (cognitive disorders that cause a progressive decline in memory, thinking, and other mental abilities that interfere with daily life), and depression (mental health condition characterized by a persistent feeling of sadness, loss of interest, and changes in mood, behavior, and thinking), and anxiety. D. Record review of staff training records revealed CNA #8 did not complete training for behavioral health needs. E. On 03/14/25 at 3:51 PM, during an interview, the Nurse Practice Educator (NPE) confirmed CNA #8 did not have behavioral health training.