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	09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Oro Center	1005 Lujan Hill Road Las Cruces, NM 88005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45042 Based on interview and record review, the facility failed to ensure that care plan was revised for 1 (R # 1) of 3 (R #1, R #2, and R #3) residents reviewed for falls. This deficient practice could likely result in staff having inaccurate information and being unable to meet resident's current needs. The findings are: A. Record review of R #1's medical record revealed that he was admitted to the facility on [DATE]. B. Record review of Event Daily Log no date revealed R #1 had seven falls during his stay at this facility on the following dates: on 08/30/20, 09/01/20, 09/02/20, 09/03/20, 09/06/20, 09/10/20 and 09/11/20. C. Record review of Care Plan for R #1 revealed the following: 1. Focus: Resident is at risk for falls: decrease safety awareness, TBI (traumatic brain injury, a form of brain injury, occurs when a sudden trauma cause damage to the brain), use of psychotropic (drug that affects behavior, mood, thoughts, or perception) medications .Date initiated: 08/28/20 and Revised:09/10/20. 2. Goal: Resident will have no fall with injury x 90 days (next 90 days). Goal not met; fall on 08/30/20, 09/01/20, 09/02/20, 09/03/20, 09/06/20, 09/10/20 and 09/11/20. Date initiated: 08/28/20, Revised: 08/28/20 and Targeted (the date set to finish an event or goal) : 09/14/20. 3. Interventions: Therapy/Rehab-PT(treatment by methods such as massage, heat treatment and exercise rather than by medication or surgery) treatment 5x per week. Date initiated: 08/28/20, Revised: 08/28/20. Remind him to use call light when attempting to ambulate (walk) or transfer. Date initiated: 08/28/20, Revised: 09/10/20. Maintain a clutter-free environment in the resident's room and consistent furniture arrangement. Date initiated: 08/28/20, Revised: 09/10/20. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2021
NAME OF PROVIDER OR SUPPLIER Casa DE Oro Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. On 09/23/21 at 2:13 pm, during an interview with CNA #1, he stated [Name of R #1] always wanted to get up and walk. He was alert but had moments of confusion. We all tried to explain it to him he was unable to walk, I remember we had a floor mat by his bed to prevent him from getting injured. E. On 09/23/21 at 2:32 pm, during an interview, the DON was asked about R #1's care plan, She confirmed the R #1's care plan was not revised and no record of IDT (Interdisciplinary team) meeting (meeting that allows team members to share information and updates, solve problems, and develop and update the plan of care) was available.

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NAME OF PROVIDER OR SUPPLIER: Casa DE Oro Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - 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** 45042 Based on observation, interview, and record review, the facility failed to ensure that a resident with Pressure Ulcers (an injury to the skin and underlying tissue, caused by prolonged pressure on the skin) received the necessary treatment and services, consistent with professional standards of practice for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for Pressure Ulcers, when they failed to: 1) Initiate wound care order for R #1's pressure wound upon admission to the facility, 2) Start antibiotic treatment (treatment for bacterial infection) for R #1's pressure wound in a timely manner, 3) Provide documentation consistently in accordance with wound care orders for R #1's pressure wound , 4) Initiate a wound vac (vacuum-assisted closure of a wound, a type of therapy to help wound heal) for R #1's pressure wound per Physician request, 5) Obtain weekly wound assessment and measurements for R #1's pressure wound, and 6) Place the R #1 under contact precautions for MRSA (METHICILLIN RESISTANT Staphylococcus aureus infection caused by bacteria that are resistant to commonly used antibiotics. Very infectious organism that requires contact precautions) . This deficient practice has likely caused R #1 wound to became infected and not healed and ultimately result in amputation (limb loss) at level between knee and ankle to the right lower leg. The findings are: Wound Orders A. Record review of R #1's Convalescent Order (orders from previous facility that R #1 came from) revealed: 1. 07/21/20 Wound care to right heel trauma. Soak 4x4's with Dakins's solution (use to prevent and treat skin and tissue infection) and let sit 15 minutes before placing new wound vac then cleanse with NS (normal saline), apply black foam, drape (cloth) and wound vac . B. Record review of R #1's medical record indicate the following: 1. R #1 was admitted to the facility on [DATE] as a transfer from sister facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. R #1's diagnosis Diabetic Mellitus (disease that result in too much sugar in the blood), Chronic kidney disease stage 3 (Stage 3 kidney disease means that the kidney's function has been cut by half, and most patients experience ancillary problems), Atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), Obesity, Essential hypertension (high blood pressure that doesn't have a known secondary cause), chronic ischemic heart disease (Damage or disease in the heart's major blood vessels), heart failure (chronic condition in which the heart doesn't pump blood as well as it should). C. Record review of Nursing Documentation V6 (nursing assessment) 08/03/20 revealed the reason for admission wound care to right heel pressure wound. D. Record review of R #1's Physician's Order revealed the following: 1. 08/03/20 monitor wound site daily for status of surrounding tissue and wound pain (no wound care orders documented until 08/08/20). 2. 08/08/20 Dakins (1/4 strength) solution 0.125% (sodium Hypochlorite)(to prevent and treat skin and tissue infections), apply to R (right) foot wound(s) topically (to skin) every day and evening shift. (first wound care order). 3. 09/17/20 wound care to right plantar (long, thin ligament directly beneath the skin on the bottom of foot) heel/foot pressure wound 1 time a day every Monday, Wednesday, and Friday. Antibiotic Treatment/Isolation precaution E. Record review of Physician's Order for R #1's revealed: 1. 08/06/20 Wound culture (is a laboratory test in which microorganisms from a wound are grown in a special growth medium. It is done to find and identify the microorganism causing an infection in a wound or an abscess) of right heel wound . (prior to 1st wound care order). 2. 08/07/20 Wound Culture . completed. F. Record review of R #1's Lab Results Report dated 08/12/20 revealed: Heavy Growth of Pseudomonas aeruginosa (is a type of bacteria (germ) that is found commonly in the environment, like in soil and in water) isolated and Moderate Growth of METHICILLIN RESISTANT Staphylococcus aureus isolated. G. Record review of R #1's Physician's Orders revealed: 1. 08/13/20 Bactrim DS (type of antibiotics) Tablet 800-160 MG. Give one tab orally two times a day for Pseudomonas and MRSA in right plantar foot wound for 10 days. 2. 08/13/20 Zosyn Solution Reconstituted (type of antibiotics) . every 6 hours for pseudomonas and MRSA in right plantar foot wound for 10 Days . 3. Record review of R #1's Physician's Orders revealed no order for contact precaution for MRSA. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	H. Record review of R #1's Medication Administration Records revealed: 1. 08/14/20 start date of antibiotic therapy Bactrim DS and Zosyn Solution . I. Record review of Infectious Disease Management policy dated 11/15/20 revealed: Patients who have evidence of an infectious disease will be treated according to physician/provider and current guidelines. All suspect or diagnosed cases will be reported to the infection preventionist or designee. Wound Care J. Record review of Treatment Administration Report (TAR) for month of August 2020 and September 2020 revealed : 08/08/20 Dakins (1/4 strength) solution 0.125% (sodium Hypochlorite), apply to R foot wound(s) topically (to skin) every day and evening shift. 1. Wound treatment was performed eight times during month of August on the following dates and times: 6 am-2 pm: 08/09/20, 08/10/20, 08/11/20, 08/12/20, and 08/22/20. 6 pm-6 am: 08/08/20, 08/11/20, and 08/12/20. 2. Wound treatment was performed thirteen times during month of September on the following dates and times: 6 am-2 pm: 09/10/20, 09/11/20, 09/13/20, 09/14/20,09/15/20, 09/16/20, and 09/17/20. 6 pm-6 am: 09/10/20, 09/11/20, 09/12/20, 09/14/20, 09/15/20, and 09/16/20. K. On 09/22/21 at 2:55 pm, during an interview with the DON, she confirmed that there was missing documentation for R #1's right heel pressure wound. Wound Measurement L. Record review of progress notes (wound measurement) revealed the following: 1. 08/04/20 wound measurement - right heel surgical site, 12 x 4 x 0.2 cm. 2. 08/12/20 wound measurement - right plantar heel/foot surgical site 11.5 x 5 x 0.2 cm. 3. 09/04/20 wound measurement - right plantar foot surgical site 9 x 5 x 0.2 cm. 4. No other documentation was found for wound measurements. M. Record review of Skin Integrity Management policy dated 12/20/19 revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. Perform skin inspection on admission/readmission and weekly. Document on treatment administration record (TAR) or in [name of electronic medical records]. 2. Perform wound observations and measurements and complete Skin Integrity Report upon initial identification of altered skin integrity, weekly and with anticipated decline of wound. Wound Vac N. Record review of R #1's Progress Notes revealed the following: 1. 08/12/20 Wound to right foot patient is going to continue with treatment and be followed closely by wound care nurse who is going to put wound VAC back on and change Monday, Wednesday, Friday patient is waiting to see [name of doctor] before getting wrapped to help with fluid retention. 2. 08/17/20 first documentation of R #1 wound vac (before order in place). O. Record review of R #1's Physician's Orders dated 08/19/20 Wound Vac therapy to right heel . (first order for wound vac) P. Record review of R #1's Care Plan date 08/04/20 revealed : DTI (Deep Tissue Injury: injury to the underlying tissue bellow the skin surface and not an open wound) pressure ulcer. Location: right heel. Care plan was not updated to show the on going status of the wound when it became open from DTI and the wound vac was not care planned. Q. Record review of R #1 Progress Notes revealed the following: 1. 10/06/20 R #1 sent to local hospital. 2. 10/21/20 R #1 returned from hospital with right lower leg amputation. R. On 09/22/21 at 2:55 pm, during an interview with the DON, she stated I was not here during that time, I did not look at the wound, but I believe if resident would start the antibiotic and wound vac sooner, she could benefit from that. The DON confirmed that the wound was not measured weekly per care plan and facility policy. The DON also confirmed facility should have placed R #1 under contact precautions per culture results of MRSA and they failed to to that. The DON also confirmed they failed to document wound care regularly per order. The DON continued to state It was a delay from the day of admission and start of the wound care, I cannot confirm if that could contribute to the amputation or not. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	S. On 09/23/21 at 9:44 am, during an interview with the Nurse Practitioner (NP), she was asked about R #1 pressure wounds and the care she received during her stay at this facility. The NP stated This resident came in very sick, she had multiple health issues. We were trying to focus on what to solve because it was so many different illnesses. I didn't start the antibiotics because I did not have the result of the culture. Resident admitted with wound care orders, her admission orders should have the continuation of the wound care from the sister facility (Convalescent care order dated 07/21/20), I don't know why they did not continue the orders (here). The NP was asked about R #1's wound vac, she stated I have no idea why it was such a long delay to place the wound vac since the day I recommended it . The NP continued to state R #1 had many diagnosis that would have likely also contributed to R #1's amputation, .I think a lot could be done better, I think a lot was missed, but not intentionally . T. On 10/06/21 at 8:18 am, during an interview with the DON, she confirmed R #1's wound to her right heel was a pressure ulcer. The DON stated she was unsure why some nurses documented R #1's right heel pressure ulcer as something other than a pressure wound. The DON also confirmed that if R #1's wound was draining it was no longer a DTI and it was an open pressure ulcer. This deficient practice was cited as past noncompliance: Review of onsite residents sampled for pressure wounds revealed the following: 1. Orders in place for wound care, 2. No concerns for antibiotic treatment, 3. Wound documentation was consistent wound care orders, 4. No concerns for wound vac, 5. No concerns for weekly wound assessment and measurements, 6. No concerns for contact precautions for MRSA, and 7. New administration and new staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34303 Based on interview and record review the facility failed to supervise residents at risk for elopement for 1 (R #5) of 1 (R #5) random residents sampled, when they failed to 1) Monitor (check) regularly R #5's life saver ankle bracelet (a devise that is use to help find residents if they elope) to ensure he still had it on his ankle, when he managed to take it off and discard it in the hallway trash can when he eloped, and 2) Have staff monitoring the hallway when one CNA was on break and the other CNA was assisting a resident in the shower during the elopement. This deficient practice could likely result in residents leaving the building and getting hurt or injured. The findings are: A. Record review of R #5's Elopement Evaluation dated 06/15/21 revealed R #5 has A history of actual elopement or attempted elopement. B. Record review of the progress notes revealed the following: 1. On 09/10/21 10:30 am .Note Text: At 1007 was notified by [name of of CNA #5] CNA, that she had just seen [name of R #5] walking down the street, Past [name of road]. At this time I, [Name of LPN #5] then proceeded to RUN to door and head outside to go in the direction in which [Name of R #5] was last seen. I continued to run until CNA [Name of CNA #5] drove by and informed me that the transfer van from the facility had just picked him up. I then also got picked up by transfer van and sat with [Name of R #5] in the back seat and assessed him (for any possible health concerns or injuries from elopement) and asked where he was going and how he was able to get out of the facility. [Name of R #5] was talking in word salad (a confused or unintelligible mixture of seemingly random words and phrases), and I was unable to understand meaning behind his conversation . 2. On 09/10/21 11:25 am, eMAR PN Note Text: Project life saver bracelet is and has been on [Name of R #5] right ankle. Bracelet had been placed on [Name of R #5] Right ankle since he was admitted on the North Unit. Spoke with [Name of life saver worker] . I did state that [name of R #5] did indeed elope the facility. [Name of life saver worker] educated me that in the instance that this incident happens again, he is the one to be called IMMEDIETLY!! [sic] 3. On 9/10/21 1:21 pm .Summary for Providers . C. New Intervention Orders: - Other - Insure [sic] that [Name of R #5] is wearing safety bracelet to right ankle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. On 09/23/21 at 12:20 pm, during an interview Unit Manager (UM) #3 was asked about what happened during R #5's elopement, UM #3 stated that the nurse for R #5's unit was at the nurses station charting, the medication tech was doing the medication pass, CNA #5 was working R #5's hallway and was the staff member who found R #5 when she was on lunch break and the other CNA was assisting a resident in the shower. UM #3 continued, R #5 had taken off his live saver ankle bracelet and discarded it in the hallway trash can. UM #3 stated that we were unsure how he got out of the building. The UM #3 confirmed that resident was assessed (for any possible health concerns or injuries from elopement) and did not have injuries or problems from the elopement. The UM #3 was asked if R #5 had a history of elopement or attempted elopement. She stated R #5 did have a history on the other unit he had attempted to leave the building once of twice but never succeeded in leaving the building. D. On 09/23/21 at 2:39 pm, during an interview the DON confirmed that CNA #5 should not have gone on break until other CNA was out of shower. The DON also confirmed that the facility should have been monitoring/checking regularly R #5's life saver bracelet on his ankle to make sure he had not taken it off.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34303 Based on observation and interview the facility failed to follow proper infection control practices for all 11 residents in the new admissions unit/14 day quarantine unit (residents were identified by the Census List provided by the Administrator on 09/22/21) when they failed to have staff follow proper Personal Protective Equipment (PPE) (is equipment worn to minimize exposure to hazards) protocols. This deficient practice could likely result in the spread of infection and could cause residents to become sick from the staff. The findings are: A. On 09/22/21 at 12:12 pm, during an observation LPN #7 walked into a residents room. LPN #7 had on a N-95 with only one strap on his N95 Mask, goggles, and no isolation gown. B. On 09/22/21 at 12:13 pm, during an interview LPN #7 confirmed that he only had one strap on his N95 mask on with the other strap cut off. LPN #7 stated that it was too tight for him. LPN #7 was asked about the PPE that should be worn in the new admissions unit he stated The guidance changes day to day, but today we wear the N 95 mask and eye protection. We are not gowning up to go into room unless it is resident on C. Diff (Clostridioides difficile is a bacterium that causes severe diarrhea and colitis). C. On 09/22/21 at 12:14 pm, during an observation of the new admissions unit revealed no isolation gowns outside resident's rooms, except 2 rooms at the end that were on contact precautions for C. Diff who had gowns available outside their rooms. D. On 09/22/21 at 12:28 pm, during an interview the DON confirmed that LPN #7 should be wearing both straps on his N95 mask. The DON was asked about the PPE that should be worn in the new admissions unit, she stated that the staff should be wearing N95 mask, eye protection, and an isolation gown, but for the residents that have been there longer than 14 days they don't have to wear an isolation gown, unless there are contact precautions. The DON stated that they had 2 residents on contact precautions for C. Diff. and will confirm who is under the 14 days quarantine. E. On 09/22/21 at 2:43 pm, during an interview the DON confirmed that only one resident, R #15, had met the 14 day quarantine, staff should be wearing the isolation gowns for all 10 other residents on that unit.