STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OF SUPPLIER: CASA DE ORO CENTER

STREET ADDRESS, CITY, STATE, ZIP: 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.

F 0225
Level of harm - Minimal harm or potential for actual harm
Residents Affected - Some

1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.

Residents Affected - Some

Based on record review and interview, the facility failed to report and investigate unobserved injuries and unwitnessed falls with injuries for 3 (R #1, #52, and #70) of 6 (R #1, #33, #52, #68, #72, and #147) residents reviewed for falls and injuries of unknown origin. This deficient practice could likely result in residents being at further risk for injury. The findings are:

R #1

[NAME] Record review of facility's Event Tracking Log indicated R #1 obtained an unobserved injury on 11/21/16.

B. Record review of facility's Risk Management System (RMS) revealed: 11/21/16: (Name of R #1)'s Event - Unobserved injury.

I. Review of electronic record dated 12/13/16 read, This is a follow-up note from the change in condition-medical that occurred on 12/13/2016; Status of condition: change. D.A.T.A. Follow up fall noted from previous shift, bruising all over the face and large hematoma on forehead noted, up in bed at this time appears to be talking incoherently and having small rapid burst of breathing episodes.

Record review of facility documentation revealed no hand written report or follow up for R #1's unobserved injury on 11/21/16.

E. On 12/12/16 at 3:27 pm, during interview, the Director of Nursing (DON) stated, For (name of R #1)'s injury, I should have reported it (to State) and didn't.

R #52

F. Record review of facility's Event Tracking Log indicated R #52 had a fall on 12/11/16.

Record review of facility's Risk Management System (RMS) revealed: 12/11/16: (Name of R #52)'s Event - Unobserved injury.

I. Review of electronic record dated 12/13/16 read, This is a follow-up note from the change in condition-medical that occurred on 12/13/2016; Status of condition: change. D.A.T.A. Follow up fall noted from previous shift, bruising all over the face and large hematoma on forehead noted, up in bed at this time appears to be talking incoherently and having small rapid burst of breathing episodes.

J. On 01/12/17 at 3:14 pm, during an interview, the Administrator stated. We report to State incidents with injuries of unknown origins and we investigate. In regards to an unobserved injury or unobserved fall, when asked what should surveyors expect to see in the file, Administrator stated. A hand written report and a follow up.

K. Review of facility documentation revealed no hand written report or follow up for R #1's unobserved injury on 11/21/16.

L. On 12/12/16 at 3:27 pm, during interview, the Director of Nursing (DON) stated, For (name of R #52)'s injury, I should have reported it and didn't.

R #70

L. Review record of facility's Event Tracking Log indicated R #70 had a fall on 12/16/16.

M. Record review of RMS report revealed: R #70, Event-Fall, Injury- Abrasion, Description- Called to outside yard by CNA who found resident on the ground. Examined by Doctor-No. No witnesses listed.

N. Review record of electronic record dated 12/13/16 read, This is a follow-up note from the change in condition-medical that occurred on 12/13/2016; Status of condition: change. D.A.T.A. Follow up fall noted from previous shift, bruising all over the face and large hematoma on forehead noted, up in bed at this time appears to be talking incoherently and having small rapid burst of breathing episodes.

O. On 01/12/17 at 3:14 pm, during an interview, the Administrator was asked to look at Event Tracking Log for event date 12/16/16 regarding a fall for R #70. Administrator stated, If we characterized an event as a fall, we would not necessarily report the fall. We report to State incidents with injuries of unknown origins. This deficient practice could likely result in residents being at further risk for injury. The findings are:

P. On 12/12/16 at 3:27 pm, during an interview, the DON stated, For (name of R #70)'s injury, I should have reported it and didn't.

F 0226
Level of harm - Minimal harm or potential for actual harm
Residents Affected - Some

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.

Based on record review and interview, the facility failed to follow their policies and procedures when they failed to report injuries of unknown origin to State Agency for 3 (R #1, #52, and #70) of 6 (R #1, #33, #52, #68, #72, and #147) residents reviewed for falls and injuries. This deficient practice has the potential to determine the cause of the incidents, identifying staff educational needs and implementing needed changes. The findings are:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER

COMPLETED

OMN. No. 0938-3691

PRINTED: 04/21/2020
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

DEFICIENCIES

Residents Affected - Some

D. On 01/10/17 at 10:18 am, observation of R #8 and R #22's bathroom revealed that the paint on the wall by toilet was peeling; lid. I am supposed to report things that are broken to the nurse.

B. On 01/10/17 at 9:26 am, during an interview, CNA #1 stated, I did not tell the nurse about . or the missing toilet tank lid. When asked, what do you consider reportable to the State? DON stated, A fall with a major injury or if they (resident) go to hospital for any reason or if they get shipped out after a fall, we report it (to State). We don't report an witnessed fall unless there is a fracture. We don't report an unwitnessed fall.

H. On 01/12/17 at 3:27 pm, during interview, the Director of Nursing (DON) stated, For (name of R #1's incident, should have reported it to (State) and didn't).

R #52

I. Record review of facility's Event Tracking Log indicated R #52 had a fall on 12/16/16.

[NAME] Record review of facility's Event Tracking Log indicated R #52 had an unwitnessed fall on 12/16/16 and was found on the floor lying on floor mat with a hematoma. When DON was asked, what do you consider reportable to the State? DON stated, A fall with a major injury or if they get shipped out after a fall, we report it (to State). We don't report an witnessed fall unless there is a fracture. We don't report an unwitnessed fall.

M. On 01/12/17 at 8:36 am, during an interview, the DON confirmed R #52 had an unwitnessed fall on 12/16/16 and was found on the floor lying on floor mat with a hematoma. When DON was asked, what do you consider reportable to the State? DON stated, A fall with a major injury or if they get shipped out after a fall, we report it (to State). We don't report an witnessed fall unless there is a fracture. We don't report an unwitnessed fall.

N. On 01/12/17 at 3:27 pm, during an interview, the DON stated, For (name of R #52's incident, should have reported it and didn't).

R #70

O. Record review of facility's Event Tracking Log indicated R #70 had a fall on 12/16/16.

P. Record review of RMS report revealed: R #70, Event-Fall, Injury- Abrasion, Description—Called to outside yard by CNA who found resident on the ground. Examined by Doctor-No. No witnesses listed.

Q. Record review of facility documentation revealed no hand written report or follow up for R #70's fall on 12/16/16.

R. On 12/16/17 at 3:14 pm, the Administrator was asked to look at Event Tracking Log for event date 12/16/16 regarding a fall for R #70, the Administrator stated, If we characterized an event as a fall, we would report it, but they don't see any necessary report the fall. 01/12/17 3:27 pm during an interview, the DON stated, (Name of R #70's incident, did not report that (to State); an unknown injury. I should have reported.

F 0253

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide housekeeping and maintenance services.

Based on observation, and interview the facility failed to provide maintenance services in order to keep resident's room's clean and functional. Based on observation and interview the facility failed to provide routine maintenance services to the residents. Based on observation and interview the facility failed to provide housekeeping and maintenance services to the residents.

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**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

**F 0525**

**Level of harm - Minimal harm or potential for actual harm**

Residents Affected - Some

Provide adequate and comfortable lighting levels in all areas.

Based on observation and interview, the facility failed to provide adequate lighting in resident’s rooms for 4 (R #35, R #86, R #112, R #116) of 24 (R #2, R #6, R #7, R #176) of 24 (R #2, R #6, R #7, R #176) of 24. Observation of R #176’s light above her bed revealed a light bulb was out. There is no over head light in R #176’s room just the light fixture (with two light bulbs) attached to the wall above where the head board of R #176’s bed would be. Observation of R #141’s (R #176’s roommate) revealed one light bulb out.

B. On 01/12/17 at 8:44 am, during an observation of R #35 and R #66’s lights, both had only one light bulb working.

C. On 01/12/17 at 8:51 am, during an interview and observation of resident’s rooms, the Maintenance Director (MD) confirmed that each of the residents (R #35, R #86, R #141, and R #176) had a light bulb out above their beds. The MD also confirmed there were no work orders for any of the residents’ lights. The MD stated that maintenance does go and do rounds, but they do not catch everything, they need staff to put in work orders. When asked about the work orders, the MD stated any staff can put in a work order; however, without the work order, the MD or maintenance may not know about it.

**F 0279**

**Level of harm - Minimal harm or potential for actual harm**

Residents Affected - Few

Develop a complete care plan that meets all of a resident’s needs, with timetables and actions that can be measured.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on record review and interview, the facility failed to develop a comprehensive care plan for 1 (R #117) of 1 (R #117) resident sampled for care planning. The facility failed to document food stealing behaviors resulting in the resident putting food from another resident’s plate who has a different diet. This failed practice could result in the resident choking and possibly dying. The findings are:

A. BUILDING ______

B. Record review of a Nutritional assessment dated [DATE] revealed the resident has a regular diet with a texture of Dysphagia Puree for people who have problems with chewing and swallowing).

C. Record review of a care plan for R #137 dated 12/20/16 revealed the resident requires supervision with meals. There was no care plan addressing the behavior of taking other residents’ food.

D. On 10/11/17 at 12:57 pm, R #137 was observed to eat R #116’s soup at lunch. R #116 was served a regular texture meal. R #137 took 3 bites of the soup before the staff noticed and took the bowl of soup away from her.

E. On 10/17/17 at 1:02 pm, during an interview with LPN #1, she stated R #137 was served a puree diet.

F. On 10/17/17 at 1:36 pm, during an interview with RN #1, she stated R #137 had food from other patients’ plates.

G. On 10/17/17 at 9:51 am, during an interview with Certified Nursing Assistant (CNA) #2, he stated, R #137 used to eat R #116’s soup at lunch.

H. Record review of the facility Admission Record revealed R #137 was admitted on [DATE] with a [DIAGNOSES (X1) PROVIDER / SUPPLIER

CLIA IDENTIFICATION NUMBER

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Coordinate assessments with the pre-admission screening and resident review program for mentally ill and mentally retarded patients.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on record review and interview, the facility failed to ensure that 2 (R #82 and R #69) of 2 (R #82 and R #69) residents reviewed for Pre-Admission Screening Resident Review (PASRR) requirements were screened for PASRR level II by the (Name of State) Department of Health, Developmental Disabilities Supports Division (DOH/DDDS) PASRR Program prior to admission or at
For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

**DEFICIENCIES**

STATEMENT OF

CASA DE ORO CENTER

NAME OF PROVIDER OF SUPPLIER

FORM CMS-2567(02-99)

PREVIOUS VERSIONS OBSOLETE

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Residents Affected · Some
B. On [DATE] at 3:40 pm during an interview, RN #2 stated she had been using the inhaler that was lying in the drawer.
C. On [DATE] at 9:38 am, during an interview, LPN #2 stated, I had been using both inhalers. He came in from hospital with the inhaler that was not in a box. No expiration or open date. We should have called pharmacy and asked for a new one and not used the undated one until the new one arrived. Using the undated inhaler is a medication error since there was no date for when it was opened.
D. On [DATE] at 9:55 am, during an interview, the Director of Nursing stated, I would consider the use of the undated inhaler a medication error.

**NOTE: TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**F 0333**

Level of harm: Minimal harm or potential for actual harm

Residents Affected · Few

Make sure that residents are safe from serious medication errors.

Based on record review and interview, the facility failed to remove an unlabeled inhaler from a medication cart discovered during inspection for 1 (R #194) of 1 (R #194) randomly sampled residents. This resulted in the resident receiving a medication that possibly could result in the resident not receiving the prescribed dose of the medication resulting in his worsening of his symptoms and possibly hospitalization. The findings are: [NAME] Record review of a facility Admission Record for R #194 revealed he was admitted to the facility with a [REDACTED].

**F 0371**

Level of harm: Minimal harm or potential for actual harm

Residents Affected · Some

Based on interview and observation, the facility failed to ensure that food was served in accordance with professional standards when staff served food to residents while putting their fingers onto the plate surface that held the food for (R #25, R #30, R #123, R #141, and R #186) of 5 (R #25, R #30, R #123, R #141, and R #186) residents randomly observed in the dining room. This deficient practice can likely result in contamination of the food and cause illness. The findings are: [NAME] On 01/10/17 at 11:31 pm during dining observation, CNA #3 was observed hold the plate with her thumb on the thumb of the plate in the room, and then served R #123.

C. On 01/07/17 at 11:32 am, during observation, CNA #2 was observed to hold a plate of food with her hand with her thumb in the plate, and then served R #141.
D. On 01/07/17 at 11:36 am, during observation, CNA #2 was observed to hold a plate of food with her hand with her thumb in the plate, and then served R #141.
E. On 01/10/17 at 11:40 am, during observation, CNA #3 was observed to hold a plate of food with her hand with her thumb in the plate, and then served R #186.
F. On 01/12/17 at 8:37 am, during an interview, the Infection Control Nurse affirmed that staff should be serving food without putting their fingers in the plates. It could cause contamination of the food from what is on the staff's hands and make someone sick.

**F 0428**

Level of harm: Minimal harm or potential for actual harm

Residents Affected · Few

At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.

Based on record review and interview, the facility failed to act upon pharmacy recommendations for 1 (R #54) of 5 (R #53, R #54, R #57, and R #147) residents reviewed for unnecessary medication, when they failed to get a response from R #54's Medical Doctor (MD) after the pharmacist recommended discontinuing the medication. This deficient practice could likely result in residents receiving medication longer then needed causing effects on the nervous system, respiratory or even death. The findings are: [NAME] Record review of the physician's orders [REDACTED].
Residents Affected - Few

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on observation and interview, the facility failed to remove and dispose of expired medication in the medication carts. This failed practice could result in residents receiving medications that have lost effectiveness and possibly having a worsening of symptoms, hospitalization and death. The findings are:

NAME: On 01/11/17 at 2:20 pm, during random inspection of the medication cart for the East Unit, a stock bottle of Ferrum Gluconate (iron) 240 mg was discovered to be expired as of 11/2016. The bottle of iron was not prescribed for any one resident in the facility.

B. On 01/11/17 at 2:25 pm, during an interview, CMA (Certified Medication Aide) #1 stated. The iron should have been removed. We try an check everyday.

C. On 01/11/17 at 2:45 pm, during random inspection of the medication cart for the Main Unit, an unopened box of Gluconate (used to treat severe low blood sugar) 1 mg/ml (milliliter) for R #848 was discovered to have expired 11/2016. Review of the Medication Administration Record [REDACTED].

D. On 01/11/17 at 2:55 pm, during an interview, RN #3 stated the Gluconate should have been removed from the medication cart. We try to check everyday.

E. On 01/11/17 at 3:00 pm, during random inspection of the medication cart for the West/North Unit, a bubble pack of Ativan (used to treat anxiety disorders) 1 milligram for R #54 was discovered to be expired. The medication expired 11/2016. Review of the Medication Administration Record [REDACTED].

F. On 01/11/17 at 3:20 pm, during an interview, the Director of Nursing stated. The medication carts are supposed to be checked daily and all expired medications removed.

NAME: On 01/11/17 at 3:25 pm, during random inspection of the medication cart for the Skilled Unit, an inhaler of Symbicort (used to treat chronic obstructive ptom). The device was discovered to have no box and there were no dates indicating when it was opened or when it expires. The inhaler was a dose inhaler with 25 doses remaining. There was a sticker on the inhaler indicating the inhaler belonged to R #194.

H. On 01/11/17 at 3:40 pm, during an interview, RN #2 stated she had been using the inhaler that was in the drawer for R #194. I. On 01/12/17 at 9:38 am, during an interview, LPN #2 stated, I had been using both inhalers. He (R194) came in from hospital with the inhaler that was in not a box. No expiration or open date. We should called pharmacy and asked for a new one and not used the unit one until the new one on arrived.

NAME: On 01/12/17 at 9:55 am, during an interview, the DON stated. All expired medications should be removed from the medication cart. Nurses are supposed to go through their medication carts to check for expired medications and remove them.

K. Review of a facility Policy on Storage and Expiration Dating of Drugs, Biological's, Syringes, and Needles dated 05/16/11 revealed "... 3. Drugs and biologicals that have an expired date on the label pr are after the manufacturer/supplier guidelines/recommendations, or if contaminated or deteriorated, are stored separately, away from use, until destroyed or returned to the provider."

Residents Affected - Few

Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.

Based on observation and interview, the facility failed to maintain bathrooms in a working manner for 2 of 5 randomly sampled resident rooms and 2 rooms in the secured dementia unit. The facility failed to 1) have a toilet paper dispenser and 2) replace a toilet tank lid that was missing. This failed practice could result in the resident using these bathrooms not having working accommodates and not be able to perform care. The findings are:

NAME: On 01/09/17 at 2:15 pm, during random observation of bathroom between room 205 and 207, there was no working hot water at the bathroom sink.

B. On 01/09/17 at 2:20 pm, during random observation of bathroom between room 208 and 210, the toilet tank lid was missing.

NAME: On 01/09/17 at 2:15 pm, during random observation of bathroom between room 206 and 208, there was no working hot water at the bathroom sink.

B. On 01/09/17 at 2:20 pm, during random observation of bathroom between room 210, the toilet tank lid was missing.
For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

C. On 01/10/17 at 9:25 am, during an interview, Housekeeper #1 stated, I did not tell the nurse about the hot water or the missing toilet tank lid. I am supposed to report things that are broken to the nurse.

D. On 01/10/17 at 9:27 am, during an interview, the Unit Manager for the secured unit stated, I was not aware of the broken things. The housekeeping is supposed to tell me so I can put in a work order.