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	08/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review the facility failed to report allegations of misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) to the State Agency within 24 hours of allegation for 3 (R #16, R #17, and R #24) of 3 (R #16, R #17, and R #24) residents reviewed for misappropriation of property, when staff failed to: 1. Report an allegation of misappropriation (diversion of medication) for R #16 with in 24 hours of becoming aware of the allegation. 2. Report the allegations of misappropriation (diversion of medication) for R #17 and R #24 when staff became aware of the allegation. If the facility fails to report allegations of misappropriation of property to the state agency within 24 hours of the allegation, then corrective action may not be taken, and residents may suffer increased anxiety and worsening of their condition. The findings are: A. On 08/19/25 at 12:18 PM, during an interview, the DON stated the following: 1. On 07/30/25, UM #16 and CMA #16 talked to him about a concern regarding CMA #16 (staff member who is responsible for administering narcotic medication during the day shift) thinking that someone forged her signature on a controlled drug record (mandatory documentation required by the DEA to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) on 07/26/25 and that UM #16 had looked at R #16, R #17, and R #24 controlled drug records and noticed that a lot of the narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medications during night shift were not documented in the EMR during the month of July by LPN #16 (staff member who was responsible to administer narcotic medications during the night shift). 2. CMA #16 and UM #16 had noticed a pattern of R #16, R #17, and R #24 receiving narcotic pain medications more frequently at night during LPN #16's shifts and these residents don't usually take pain medications as frequently as what was documented. 3. LPN #16 was interviewed on 07/30/25 and denied forging CMA #16's signature on the controlled drug record. 4. LPN #16 denied taking any of the residents' medications. 5. LPN #16 admitted that she may have forgotten to document the medication administrations in the EMR. 6. The facility was unable to prove whether the narcotic medication was administered to the residents. 7. DON stated he still suspected LPN #16 was diverting (medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use) controlled medication, but he couldn't prove it. 8. The only thing the facility was able to prove was that LPN #16 had not documented controlled medications on resident's MAR's. B. Record review of the facility's document titled [name of LNP #16]; agency nurse (document outlining concerns regarding LPN taking narcotic medications from residents), no date, revealed the following: 1. Timeline of Events: a. Date of discovery (did not specify what they discovered): 07/30/25 b. Date of investigation initiated: 07/30/25 c. Date of Urine Drug Screen (UDS, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urine test to detect presence of drugs): 07/30/25 d. Date LPN #16 was placed on administrative leave: 07/30/25 e. Date of initial lab results (UDS): 08/01/25 f. Date of final lab [off site] results (UDS): 08/05/25 g. Date report (didn't specify what report) received (by Reporter): 08/07/25 2. On 07/30/25, CMA #16 reported to Unit Manager (UM) that she believed her signature had been forged on a controlled drug record. 3. A pattern was noted with LPN #16 signing out controlled medications for residents on the controlled drug record, but there were no corresponding MAR administration records found. 4. The investigation focused on three (3) residents with BIMS of 15 (names of residents were not included) who also had controlled medications ordered. 5. All three (3) residents investigated had controlled medications signed out routinely (did not specify frequency or dates that were reviewed) on nights LPN #16 worked, but not on nights LPN #16 did not work. 6. Each resident (did not specify which residents) was interviewed and denied requesting or receiving controlled medications that were signed out (on controlled drug record) multiple (did not specify quantity) times during the course of a shift (did not specify what dates). 7. LPN #16 did not document administering the controlled medications in the MAR (did not specify which specific medication, dates, or times). 8. On 07/30/25, LPN #16 was presented with the early findings of the investigation. 9. LPN #16 had no answer for not documenting controlled medications in the MAR. 10. LPN #16 said she might forget to document sometimes. 11. LPN #16 was placed on administrative leave at the end of the conversation, which included LPN #16, Human Resources, DON, and ADON. 12. LPN #16 was sent for a UDS. 13. The Market Leadership for the facility, state-agency, and sheriffs department were notified about the situation. 14. LPN #16's UDS indicated she had barbiturates (a class of depressant drugs derived from barbituric acid, used medically as anxiolytics, hypnotics, and anticonvulsants, though they carry significant risks of addiction, overdose, and other side effects) which was consistent with a medication prescribed for LPN #16. 15. Facility requested for LPN #16 to be added to a do not place list (list that ensures this agency staff member will not be hired by any other facilities in their corporation). 16. The document did not state whether the facility was able to determine if LPN #16 stole the narcotic medications. C. Record review of an email between the DON, administrator, and corporate staff, dated 07/30/25, revealed the following: 1. The subject was Diversion (the illegal redirection of a prescription drug from its intended medical purpose to illicit use) - LPN #16, dated 07/30/25. 2. CMA #16 believed her signature was forged on the controlled drug record for R #16. 3. LPN #16 had been administering hydrocodone-acetaminophen (prescription medication used for the relief of moderate to moderately severe pain. It combines an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)) 7.5-325 mg to R #16 and R #16 did not remember receiving the medication overnight/evenings. 4. R #17 had been given PRN medications at night without it being documented in the EMR (dates not provided). 5. R #24 received oxycodone acetaminophen (a prescription combination medication used to treat moderate to severe pain. It contains an opioid pain reliever (oxycodone) and a non-opioid pain and fever reducer (acetaminophen) 5-325 mg three times during night shift (dates not given). R #24 was interviewed by UM #16 and had verbalized that she doesn't usually ask for pain medication at night. 6. The pattern documented on the controlled drug record for R #16, R #17, and R #24 reflected the same pattern every time LPN #16 worked. 7. Any time other nurses worked on night shift, residents are not asking for PRN pain medications. 8. None of the medications documented on the controlled drug records by LPN #16 were documented in electronic medical record. 9. CMA #16's signatures were reviewed and appeared to be forged. 10. LPN #16 was called to go to the facility an hour before her shift on 07/30/25 to be interviewed, receive a drug test, and be placed on administrative leave pending the results of the investigation. D. Record review of the incident report submitted to the state (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	agency, dated 08/01/25 (not within 24 hours of concern on 07/30/25), revealed the following: 1. Date of incident was 07/31/25 at 11:00 AM (discrepancy with concern of diversion on 07/30/25). 2. Resident identified was R #16. 3. CMA #16 had reported to UM #16 that she believed someone had forged her signature on a controlled drug record (an official, documented account of a controlled substance's handling, including its acquisition, storage, distribution, administration, and disposal, designed to meet the strict regulatory requirements of laws in the United States). 4. UM #16 reviewed the controlled drug records and noted additional concerns. 5. UM #16 asked residents with BIMS of 15 about taking their PRN medications and a total of three residents (names not provided) had reported that they had not asked for or been given their PRN medication. 6. LPN #16 was placed on administrative leave. 7. Pain assessments were completed on all three residents (resident's names not provided). 8. The local Sheriff department was called. E. Record review of the facility's follow-up report submitted to the state agency, dated 08/07/25, revealed the following: 1. On 07/31/25, UM #16 reported there was a discrepancy in documentation for narcotics and documentation was missing from PCC. 2. CMA #16's signature did not match her true signature. 3. LPN #16 was sent for drug testing. 4. Drug test was negative for opioid medication. 5. LPN #16 agency contract was cancelled due to failing to document narcotics. 6. CMA's and nurses were educated regarding drug diversion (the transfer of legally prescribed controlled substances from the individual they were prescribed for to another person for illicit use). 7. Follow-up report did not include the names of other residents identified as being affected by the allegation of misappropriation of narcotic medication. G. Record review of the incidents reported to the state agency, no date, revealed the facility did not report concerns regarding misappropriation of property for R #17 or R #24.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of misappropriation of property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) 7 (R #16, R #17, R #18, R #24, R #25, R #26, and R #27) of 7 (R #16, R #17, R #18, R #24, R #25, R #26, and R #27) residents reviewed when staff failed to: 1. Document interviews with residents for the investigation of allegation of misappropriation of resident's narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medication. 2. Document interviews with staff for the investigation of allegation of misappropriation of resident's narcotic medication. 3. Interview potential witnesses to the allegation of misappropriation of resident's narcotic medication. 4. Review medical records for all residents in the facility with the potential for misappropriation of narcotic medications and potential for missing documentation for narcotic medications. 5. Initiate corrective action to ensure residents' narcotic medications are not being taken by someone other than the resident for whom the medication was ordered. 6. Initiate corrective action to ensure the use of narcotic medication is documented in the residents' MAR. If the facility does not adequately investigate allegations of misappropriation of resident medication, then corrective action is not implemented to protect other residents from misappropriation of medications which could cause residents to run out of their pain medications and puts residents at risk of adverse outcomes. The findings are: A. On 08/19/25 at 12:18 PM, during an interview, DON stated the following: 1. On 07/30/25, UM #16 and CMA #16 talked to him about a concern regarding CMA #16 (staff member who is responsible for administering narcotic medication during the day shift) thinking that someone forged her signature on a controlled drug record (mandatory documentation required by the DEA to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) on 07/26/25 and that UM #16 had looked at R #16, R #17, and R #24 controlled drug records and noticed that a lot of the narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medications during night shift were not documented in the EMR during the month of July 2025 by LPN #16 (staff member who was responsible to administer narcotic medications during the night shift). 2. CMA #16 and UM #16 had noticed a pattern of R #16, R #17, and R #24 receiving pain medications more at night during LPN #16's shifts and these residents don't usually take pain medications as frequently as what was documented. 3. LPN #16 was interviewed and denied forging CMA #16's signature. 4. LPN #16 denied taking any of the residents' medications. 5. LPN #16 admitted that she may have forgotten to document the medication administrations in the EMR. 6. They were unable to prove whether the narcotic medication was administered to the residents. 7. He still suspected that LPN #16 was diverting (medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use) controlled medication, but he couldn't prove it. 8. The only thing they were able to prove was that LPN #16 had not documented controlled medications on resident's MAR's. B. Record review of all of the facility's investigation documents, no date, revealed the following: 1. Staff did not document interviews with R #16, R #17, and R #24. 2. Staff did not document interviews with CMA #16, RN #16, and LPN #16. 3. Staff did not document dates and times of discrepancies found between controlled drug records and resident MAR's for R #16, R #17, and R #24. 4. Staff did not expand the investigation to determine if residents on other units were affected by discrepancies in narcotic medication documentation in the MAR. 5. Staff did not (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview other staff who may have witnessed concerns regarding controlled medications or controlled drug records. C. On 08/20/25 at 9:24 AM, during an interview, UM #16 stated she asked R #16 and R #24 questions regarding controlled medication usage. She did not document these conversations. D. On 08/21/25 at 11:09 AM, during an interview, the administrator stated she had the DON, ADON, and UM #16 complete the investigation into alleged misappropriation of controlled medications because they are more familiar with processes related to controlled medications. E. On 08/21/25 at 11:22 AM, during a joint interview with the DON, ADON, Administrator, and Corporate Resource Clinician, the following was confirmed: 1. The DON spot checked (a random, unplanned inspection or examination of a few items in a group to look for problems or ensure quality) controlled drug records on other units for concerns. 2. The DON was unable to state which residents' controlled drug records were reviewed. 3. The DON was unable to state what he was included in the spot check. 4. The DON did not document the spot checks. 5. The DON and ADON interviewed CMA #16, RN #16, and LPN #16. 6. UM #16 interviewed R #16 and R #24. 7. There was no documentation regarding interviews with residents. 8. No additional residents besides R #16 and R #24 were interviewed regarding use of controlled medications. 9. No additional staff members besides CMA #16, RN #16, and LPN #16 were interviewed to determine if there were witnesses or other concerns related to controlled medications. 10. The Corporate Resource Clinician stated that staff had been trained on diversion and documentation after the concern regarding misappropriation of controlled medications was investigated. F. On 08/21/25 at 12:14 PM, during an interview, the Nurse Educator stated the following: 1. The diversion training that was given to the nurses and CMAs after the concern regarding misappropriation of controlled medications was a training that was sent to the staff via email that required them to answer questions regarding diversion. 2. Diversion training did not include reviewing controlled drug records for patterns of controlled medication administration that seemed different than resident typical patterns. 3. Staff did not receive education regarding documentation of controlled medications after the concern regarding misappropriation of controlled medications was investigated and identified documentation as an issue. G. See findings in F658, F755, and F842 related to controlled drug records and MAR's.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards of practice for 4 (R #16, R #17, R #18, and R #24) of 4 (R #16, R #17, R #18, and R #24) residents reviewed for misappropriation of property, when staff failed to: 1. Ensure narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medications were not administered earlier than ordered for R #16 and R #17. 2. Ensure staff notified the provider when R #16 and R #17 required pain medications more frequently than ordered. 3. Ensure R #16 and R #24 did not receive narcotic medications at a higher dose than ordered. 4. Ensure staff document the narcotic medication administration on the MAR for R #16, R #17, R #18, and R #24. 5. Reassess R #16, R #17, R #18, and R #24. These deficient practices could likely lead to the resident having worsening of their medical conditions, adverse (unwanted, harmful, or abnormal result) side effects, or could lead to an overdose (happens when a toxic amount of a drug, or combination of drugs overwhelms the body) of narcotic medication. The findings are: R #16 A. Record review of R #16’s admission record, no date, revealed R #16 was admitted to the facility on [DATE]. B. Record review of R #16’s admission MDS assessment dated [DATE], revealed the following: 1. R #16 had a BIMS of 15. 2. R #16 had pain that was being treated with PRN pain medication. 3. R #16 was receiving opioid (sometimes called narcotics, are a type of drug. They include strong prescription pain relievers such as oxycodone, hydrocodone, fentanyl, and tramadol) pain medication. C. Record review of R #16’s physician’s orders, dated 05/28/25, revealed an order for hydrocodone-acetaminophen (prescription medication used for the relief of moderate to moderately severe pain. It combines an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)) 7.5-325 mg, one tablet every four (4) hours as needed for moderate to severe pain (typically refers to a level on a pain scale that ranges from roughly 4 to 10 on a 0-10 scale, where a higher number indicates more intense pain). D. Record review of R #16’s Controlled Drug Record (mandatory documentation required by the Drug Enforcement Agency (DEA) to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) for hydrocodone-acetaminophen 7.5-325 mg, dated 05/28/25 through 06/06/25, revealed the following administration dates and times: 1. 05/28/25 at 9:00 PM 2. 05/29/25 at 10:31 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. 05/29/25 at 9:00 PM 4. 05/30/25 at 10:20 AM 5. 05/30/25 at 6:27 PM 6. 05/31/25 at 12:31 AM 7. 05/31/25 at 3:06 AM (less than 4 hours from previous administration as ordered). 8. 05/31/25 at 8:00 AM 9. 05/31/25 at 5:00 PM 10. 05/31/25 at 9:00 PM 11. 06/01/25 at 1:15 AM 12. 06/01/25 at 12:35 PM 13. 06/01/25 at 8:50 PM 14. 06/02/25 at 1:45 AM 15. 06/02/25 at 11:03 AM 16. 06/02/25 at 8:05 PM 17. 06/03/25 at 2:35 AM 18. 06/03/25 at 4:17 PM 19. 06/03/25 at 8:40 PM 20. 06/04/25 at 2:00 AM 21. 06/04/25 at 10:15 AM 22. 06/04/25 at 8:00 PM 23. 06/05/25 at 10:54 AM 24. 06/05/25 at 6:00 PM 25. 06/06/25 at 1:20 PM E. Record review of R #16’s MAR, dated May 2025, revealed the following administration times for hydrocodone-acetaminophen 7.5-325 mg and effectiveness (successful in producing a desired or intended result) of medication: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. 05/29/25 at 10:31 AM, Effective (E) 2. 05/30/25 at 10:26 AM, (E) 3. 05/30/25 at 6:27 PM, (E) 4. 05/31/25 at 3:03 AM, (E) 5. 05/31/25 at 10:43 AM, (E) F. Record review of R #16’s Controlled Drug Record for hydrocodone-acetaminophen 7.5-325 mg, dated 06/06/25 through 06/28/25, revealed the following administration dates and times: 1. 06/06/25 at 10:00 PM 2. 06/07/25 at 8:25 AM 3. 06/07/25 at 6:30 PM 4. 06/07/25 at 10:15 PM (less than 4 hours from previous administration as ordered) 5. 06/08/25 at 9:52 AM 6. 06/08/25 at 9:00 PM 7. 06/09/25 at 6:50 AM 8. 06/09/25 at 7:40 PM 9. 06/10/25 at 7:21 AM 10. 6/10/25 at 8:00 PM 11. 06/11/25 at 11:10 AM 12. 06/12/25 at 10:16 AM 13. 06/12/25 at 7:00 PM 14. 06/12/25 at 11:00 PM 15. 06/13/25 at 06:30 AM 16. 06/13/25 at 6:45 PM 17. 06/13/25 at 11:15 PM 18. 06:14/25 at 3:30 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. 06/14/25 at 10:34 AM 20. 06/14/25 at 8:00 PM 21. 06/15/25 at 12:15 AM 22. 06/15/25 at 3:00 AM (less than 4 hours from previous administration as ordered) 23. 06/15/25 at 10:16 AM 24. 06/15/25 at 4:14 PM 25. 06/16/25 at 7:15 AM 26. 06/16/25 at 8:00 PM 27. 06/17/25 at 4:14 PM 28. 06/17/25 at 12:00 AM (Incorrectly documented, should have been 06/18/25) 29. 06/18/25 at 12:00 AM (duplicate entry, indicating 2 pills taken at same time, order for 1 pill every four hours as needed) 30. 06/18/25 at 7:00 PM 31. 06/19/25 at 4:19 PM 32. 06/19/25 at 6:00 PM (less than 4 hours from previous administration as ordered) 33. 06/19/25 at 10:00 PM 34. 06/20/25 at 1:30 AM (less than 4 hours from previous administration as ordered) 35. 06/20/25 at 7:10 AM 36. 06/20/25 at 5:00 PM 37. 06/20/25 at 9:00 PM 38. 06/21/25 at 12:00 AM (less than 4 hours from previous administration as ordered) 39. 06/21/25 at 3:00 AM (less than 4 hours from previous administration as ordered) 40. 06/21/25 at 9:00 AM 41. 06/21/25 at 7:30 PM 42. 06/21/25 11:00 PM (less than 4 hours from previous administration as ordered) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43. 06/22/25 at 2:30 AM (less than 4 hours from previous administration as ordered) 44. 06/23/25 at 4:17 PM 45. 06/24/25 at 1:33 PM 46. 06/24/25 at 7:00 PM 47. 06/25/25 at 10:18 AM 48. 06/25/25 at 6:30 PM 49. 06/25/25 at 10:00 PM 50. 06/26/25 at 3:30 AM 51. 06/26/25 at 9:31 AM 52. 06/26/25 at 2:00 PM 53. 06/26/25 at 7:48 PM 54. 06/26/25 at 11:15 PM (less than 4 hours from previous administration as ordered) 55. 06/27/25 at 7:00 PM 56. 06/27/25 at 11:00 PM 57. 06/28/25 at 8:00 AM 58. 06/28/25 at 10:29 AM 59. 06/28/25 at 7:40 PM 60. 06/29/25 at 11:37 AM G. Record review of R #16’s MAR, dated June 2025, revealed the following administration times for hydrocodone-acetaminophen 7.5-325 mg and effectiveness of medication: 1. 06/01/25 at 1:14 AM, (E) 2. 06/01/25 at 12:34 PM, (E) 3. 06/01/25 at 8:50 PM, (E) 4. 06/02/25 at 1:45 AM, (E) 5. 06/02/25 at 11:03 AM, (E) (continued on next page)

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	08/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. 06/02/25 at 8:05 PM, (E) 7. 06/03/25 at 2:36 AM, (E) 8. 06/03/25 at 4:17 PM, (E) 9. 06/03/25 at 8:37 PM, (E) 10. 06/04/25 at 1:59 AM, (E) 11. 06/05/25 at 10:54 AM, (E) 12. 06/06/25 at 1:16 PM, (E) 13. 06/07/25 at 8:25 AM, (E) 14. 06/07/25 at 10:15 PM, (E) 15. 06/08/25 at 9:56 AM, (E) 16. 06/08/25 at 9:10 PM, (E) 17. 06/09/25 at 7:41 PM, (E) 18. 06/10/25 at 7:31 AM, (E) 19. 06/11/25 at 11:06 AM, (E) 20. 06/12/25 at 10:15 AM, (E) 21. 06/12/25 at 11:01 PM, (E) 22. 06/13/25 at 6:45 PM, (E) 23. 06/13/25 at 11:16 PM, (E) 24. 06/14/25 at 10:34 AM, (E) 25. 06/14/25 at 8:00 PM, (E) 26. 06/15/25 at 3:00 AM, (E) 27. 06/15/25 at 10:16 AM, (E) 28. 06/15/25 at 4:14 PM, (E) 29. 06/16/25 at 7:14 AM, (E) 30. 06/17/25 at 4:13 PM, (E) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31. 06/18/25 at 12:00 AM, (E) 32. 06/18/25 at 7:16 PM, (E) 33. 06/19/25 at 4:19 PM, (E) 34. 06/20/25 at 1:30 AM, (E) 35. 06/20/25 at 7:21 AM, (E) 36. 06/21/25 at 3:00 AM, (E) 37. 06/21/25 at 7:05 PM, (E) 38. 06/21/25 at 11:00 PM, (E) 39. 06/23/25 at 4:17 PM, (E) 40. 06/24/25 at 1:33 PM, (E) 41. 06/25/25 at 10:18 AM, (E) 42. 06/25/25 at 6:36 PM, (E) 43. 06/26/25 at 3:29 AM, (E) 44. 06/26/25 at 11:15 PM, (E) 45. 06/28/25 at 2:00 AM, (E) 46. 06/28/25 at 10:29 AM, (E) 47. 06/28/25 at 7:40 PM, (E) 48. 06/29/25 at 11:37 AM, (E) H. Record review of R #16’s entire medical record, no date, revealed the following: 1. Staff did not document whether R #16’s pain was reassessed for effectiveness after medication administration for the administration times that were not documented on the May and June 2025 MAR’s. 2. Staff did not document whether the provider was notified that R #16 was having pain that required medication to be administered more frequently than ordered. R #17 I. Record review of R #17’s admission documents, no date, revealed R #17 was admitted to the facility on [DATE]. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #17’s quarterly MDS, dated [DATE], revealed the following: 1. R #17 had a BIMS of 15. 2. R #17 had pain that was being treated with PRN pain medication. 3. R #17 was receiving opioid pain medication. K. Record review of R #17’s physician order, dated 06/16/25, revealed an order for hydrocodone-acetaminophen 5-325 mg one tablet every six (6) hours as needed for moderate to severe pain (typically refers to a level on a pain scale that ranges from roughly 4 to 10 on a 0-10 scale, where a higher number indicates more intense pain). L. Record review of R #17’s Controlled Drug Record for hydrocodone-acetaminophen 5-325 mg, dated 07/03/25 through 07/13/25, revealed the following administration dates and times: 1. 07/03/25 at 9:27 AM 2. 07/03/25 at 5:41 PM 3. 07/03/25 at 10:49 PM (less than 6 hours from previous administration as ordered) 4. 07/04/25 at 3:00 AM (less than 6 hours from previous administration as ordered) 5. 07/04/25 at 8:30 AM (less than 6 hours from previous administration as ordered) 6. 07/04/25 at 4:32 PM 7. 07/04/25 at 9:30 PM (less than 6 hours from previous administration as ordered) 8. 07/05/25 at 2:30AM (less than 6 hours from previous administration as ordered) 9. 07/05/25 at 12:56 PM 10. 07/05/25 at 6:30 PM (less than 6 hours from previous administration as ordered) 11. 07/05/25 at 10:30 PM (less than 6 hours from previous administration as ordered) 12. 07/06/25 at 10:52 AM 13. 07/06/25 at 5:00 PM 14. 07/06/25 at 11:00 PM 15. 07/07/25 at 10:15 AM 16. 07/07/25 at 5:41 PM 17. 07/08/25 at 9:28 AM (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. 07/08/25 at 6:06 PM 19. 07/09/25 at 2:00 AM 20. 07/09/25 at 6:40 PM 21. 07/09/25 at 11:00 PM (less than 6 hours from previous administration as ordered) 22. 07/10/25 at 9:00 AM 23. 7/10/25 at 6:46 PM 24. 07/11/25 at 12:15 AM (less than 6 hours from previous administration as ordered) 25. 07/11/25 at 7:15 AM 26. 07/11/25 at 4:37 PM 27. 07/11/25 at 10:00 PM (less than 6 hours from previous administration as ordered) 28. 07/12/25 at 8:59 AM 29. 07/12/25 at 3:34 PM 30. 07/12/25 at 9:30 PM 31. 07/13/25 at 10:05 AM M. Record review of R #17’s MAR, dated July 2025, revealed the following administration times for hydrocodone-acetaminophen 5-325 mg and effectiveness of medication: 1. 07/03/25 at 9:27 AM, (E) 2. 07/03/25 at 5:41 PM, (E) 3. 07/03/25 at 10:44 PM, (E) 4. 07/04/25 at 8:33 AM, (E) 5. 07/04/25 at 4:31 PM, (E) 6. 07/04/25 at 9:23 PM, (E) 7. 07/05/25 at 2:38 AM, (E) 8. 07/05/25 at 12:56 PM, (E) 9. 07/05/25 at 6:31 PM, (E) (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. 07/06/25 at 2:29 AM, (E) 11. 07/06/25 at 10:52 AM, (E) 12. 07/06/25 at 5:03 PM, (E) 13. 07/07/25 at 10:15 AM, (E) 14. 07/07/25 at 5:41 PM, (E) 15. 07/08/25 at 9:28 AM, (E) 16. 07/08/25 at 6:16 PM, (E) 17. 07/09/25 at 6:41 PM, (E) 18. 07/09/25 at 11:00 PM, (E) 19. 07/10/25 at 9:35 AM, (E) 20. 07/10/25 at 6:43 PM, (E) 21. 07/11/25 at 12:14 AM, (E) 22. 07/11/25 at 7:15 AM, (E) 23. 07/11/25 at 4:37 PM, (E) 24. 07/11/25 at 10:50 PM, (E) 25. 07/12/25 at 8:59 AM, (E) 26. 07/12/25 at 3:34 PM, (E) 27. 07/13/25 at 10:05 AM, (E) N. Record review of R #17’s entire medical record, no date, revealed the following: 1. Staff did not document whether R #17’s pain was reassessed for effectiveness after medication administration for the administration times that were not documented on July 2025 MAR. 2. Staff did not document whether the provider was notified that R #17 was having pain that required medication to be administered more frequently than ordered. R #18 O. Record review of R #18’s admission documents, no date, revealed R #18 was admitted to the facility on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. Record review of R #18’s quarterly MDS, dated [DATE], revealed the following: 1. R #18 had a BIMS of 15. 2. R #18 had pain that required the use of PRN pain medication. 3. R #18 was receiving opioid pain medication. Q. Record review of R #18’s physician’s order, dated 06/14/25, revealed an order for oxycodone (a powerful opioid pain medication used to treat moderate to severe pain) 5 mg every four (4) hours as needed for pain level 6-10. R. Record review of R #18’s Controlled Drug Record for oxycodone 5 mg, dated 08/10/25 through 08/20/25, revealed the following administration dates and times: 1. 08/10/25 at 8:59 PM 2. 08/11/25 at 8:17 AM 3. 08/11/25 at 8:00 PM 4. 08/12/25 at 8:23 AM 5. 08/12/25 at 8:00 PM 6. 08/13/25 at 7:43 AM 7. 08/13/25 at 9:05 PM 8. 08/14/25 at 7:58 AM 9. 08/14/25 at 9:35 PM 10. 08/15/25 at 8:41 AM 11. 08/15/25 at 8:00 PM 12. 08/16/25 at 8:00 PM 13. 08/17/25 at 8:17 AM 14. 08/17/25 at 7:00 PM 15. 08/18/25 at 9:23 AM 16. 08/18/25 at 10:19 PM 17. 08/19/25 at 9:02 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. 08/19/25 at 8:55 PM 19. 08/20/25 at 9:11 AM 20. 08/20/25 at 4:43 PM 21. 08/20/25 at 10:35 PM S. Record review of R #18’s MAR, dated August 2025, revealed the following administration times for oxycodone 5 mg and effectiveness of medication: 1. 08/10/25 at 9:53 PM, (E) 2. 08/11/25 at 8:17 AM, (E) 3. 08/12/25 at 8:23 AM, (E) 4. 08/12/25 at 8:00 PM, (E) 5. 08/13/25 at 7:43 AM, (E) 6. 08/13/25 at 9:07 PM, (E) 7. 08/14/25 at 7:58 AM, (E) 8. 08/14/25 at 9:32 PM, (E) 9. 08/15/25 at 8:41 AM, (E) 10. 08/16/25 at 8:00 PM, (E) 11. 08/17/25 at 8:00 PM, (E) 12. 08/18/25 at 9:16 AM, (E) 13. 08/19/25 at 9:03 AM, (E) 14. 08/20/25 at 9:11 AM, (E) 15. 08/20/25 at 4:43 PM, (E) 16. 08/20/25 at 10:36 PM, (E) T. Record review of R #18’s entire medical record, no date, revealed staff did not document whether R #17’s pain was reassessed for effectiveness after medication administration for the administration times that were not documented on the August 2025 MAR. R #24 (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	U. Record review of R #24’s Administration Record, no date revealed R #24 was admitted to the facility on [DATE]. V. Record review of R #24’s physician orders revealed an order dated 11/22/24, for Oxycodone-Acetaminophen 5-325mg (a combination pain-relief medication prescribed to treat acute moderate-to-severe pain), give 1 tablet by mouth every 4 hours as needed for pain. W. Record review of R #24’s Controlled Drug Record for Oxycodone-Acetaminophen 5-325 dated 07/16/25 through 08/18/25 revealed staff documented administering R #24 Oxycodone-Acetaminophen earlier than ordered on the following dates and times: 1. On 07/16/25 at 7:30 PM Oxycodone-Acetaminophen was documented as given. 2. On 07/17/25 at 12:00 AM Oxycodone-Acetaminophen was documented as given (30 minutes earlier than ordered). 3. On 07/26/25 at 1:00 AM Oxycodone-Acetaminophen was documented as given twice. X. On 08/21/25 at 12:21 PM, during an interview, LPN #17 stated the following: 1. Narcotic medication that is ordered as needed should not be administered any earlier than the time frame ordered. 2. The provider should be contacted if the resident is requesting pain medication more frequently than ordered. 3. Resident must be reassessed for effectiveness after pain medication is administered. 4. The EMR notifies the nurse that a pain assessment is required to assess the resident for effectiveness of the medication after pain medication administration is documented in the EMR. 5. If someone did not document the pain medication administration in the EMR, the nurse would not be notified that a pain assessment was due for the resident. Y. On 08/21/25 at 12:24 PM, during an interview, CMA #17 stated the following: 1. All narcotic medications should be documented on the controlled drug sheet and the residents’ MAR. 2. Narcotic medication that is ordered as needed should not be administered any earlier than the ordered time frame. 3. He notifies the nurse if the resident is requesting pain medication more frequently than ordered. 4. He notifies the nurse when pain medications are administered so the nurse can reassess the resident for the effectiveness of the medication administration. Z. On 08/21/25 at 11:19 PM, during an interview, the DON confirmed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. He was unsure how early a narcotic pain medication that was ordered PRN could be administered, but he thought 30 minutes early would be ok. 2. He was not aware that staff had been administering R #16 and R #17’s narcotic medication earlier than ordered. 3. Staff were expected to document administration of all medication on the residents’ controlled drug record and the MAR. 4. Staff were expected to reassess residents for pain after administering pain medication to determine if the medication was effective. 5. Staff were expected to document the effectiveness of pain medication on the MAR. AA. On 08/21/25 at 3:09 PM, during an interview, NP #16 stated the following: 1. She looks at the MAR to determine the resident’s usage of pain medications. 2. She does not look at the controlled drug records. 3. If staff don’t document in the MAR, she would not know how frequently the resident used pain medication and would not be able to accurately assess the resident’s pain management. 4. If a resident requested their pain medication more frequently than ordered, that would indicate that the resident’s pain was not controlled, and she would refer the resident to pain management. 5. She had never been notified that R #16 received his pain medication more frequently than ordered. 6. Giving a resident their narcotic pain medication 30 minutes early would be considered early administration. 7. She would expect staff to notify her if a resident was requesting their pain medications early more frequently than once a week.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met when staff failed to keep controlled drug records (mandatory documentation required by the Drug Enforcement Agency (DEA))to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) for controlled medication (drugs or chemicals that the government regulates because they can be easily abused and lead to addiction.) for 4 (R #17, R #24, R #25 and R #27) of 7 (R #16, R #17, R #18, R #24, R #25, R #26, and R #27) residents reviewed for misappropriation of property. This deficient practice could likely lead to a delay in the incident investigation process and lead to potential drug misuse or diversion (medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use). The findings are: R #17 A. Record review of R #17’s admission documents, no date, revealed R #17 was admitted to the facility on [DATE]. B. Record review of R #17’s physician orders, multiple dates, revealed the following: 1. An order dated 03/12/25, for hydrocodone-acetaminophen (prescription medication used for the relief of moderate to moderately severe pain. It combines an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)) 5-325 mg one tablet every four (4) hours as needed for severe pain (an intense, often sudden or long-lasting sensation that acts as a warning sign for injury or disease, or it can be a symptom of chronic pain, which is a disease itself) 7-10 on pain scale (typically refers to a level on a pain scale, where a higher number indicates more intense pain) for 30 days. 2. An order dated 04/14/25, for hydrocodone-acetaminophen 5-325 mg one tablet every six (6) hours as needed for moderate to severe pain 6-10 on pain scale for 30 days. 3. An order dated 05/19/25, for hydrocodone-acetaminophen 5-325 mg one tablet every six (6) hours as needed for moderate to severe pain for 12 days. 4. An order dated 05/31/25 for hydrocodone-acetaminophen 5-325 mg one tablet every six (6) hours as needed for pain for 14 days. 5. An order dated 06/16/25, for hydrocodone-acetaminophen 5-325 mg one tablet every six (6) hours as needed for moderate to severe pain (no end date). C. Record review of R #17’s controlled drug records for hydrocodone-acetaminophen 5-325 mg, dated 03/13/25 through 08/13/25, revealed the following: 1. A controlled drug record with documentation for R #17’s medication uses for dates and times between 03/13/25 at 2:26 PM and 05/19/25 at 2:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A controlled drug record with documentation for R #17’s medication uses for dates and times between 06/12/25 at 11:40 PM and 07/03/25 at 6:00 AM. 3. A controlled drug record with documentation for R #17’s medication uses for dates and times between 07/24/25 at 9:00 AM through 08/13/25 at 10:14 AM. 4. There were no controlled drug records for 05/19/25 at 2:00 PM through 06/12/25 at 11:40 PM. 5. There were no controlled drug records for 07/03/25 at 6:00 AM through 07/24/25 at 9:00 AM. D. Record review of R #17’s MAR, dated May 2025, revealed R #17 had hydrocodone-acetaminophen 5-325 mg documented as administered 14 times between 05/19/25 at 2:00 PM and 05/31/25. E. Record review of R #17’s MAR, dated June 2025, revealed R #17 had had hydrocodone-acetaminophen 5-325 mg documented as administered 17 times between 06/01/25 and 06/12/25 at 11:40 PM. F. Record review of R #17’s MAR, dated July 2025, revealed R #17 had had hydrocodone-acetaminophen 5-325 mg documented as administered 48 times between 07/03/25 at 6:00 AM and 07/24/25 at 9:00 AM. R #24 G. Record review of R #24’s admission Record, no date revealed R #24 was admitted to the facility on [DATE]. H. Record review of R #24’s physician orders revealed an order dated 11/22/24, for Oxycodone-Acetaminophen 5-325mg (a combination pain-relief medication prescribed to treat acute moderate-to-severe pain), give 1 tablet by mouth every 4 hours as needed for pain. I. Record review of the Controlled Drug Record revealed R #24’s record for Oxycodone-Acetaminophen 5-325 dated 06/12/25 through 07/15/25 revealed missing pages from the record. J. On 08/20/25 at 9:24 AM, during an interview, the DON confirmed the following: 1. Narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medications are controlled drugs. 2. Every order for a controlled medication for a resident has a controlled drug record to account for the narcotic medication. 3. Staff were expected to document on the controlled drug record and the MAR each time a controlled medication was used. 4. Staff were expected to place completed controlled drug records in a box for the medical records staff to scan into the resident’s medical record. 5. The facility was expected to keep the controlled drug records for all narcotic medications received at the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The controlled drug record for R #17’s hydrocodone-acetaminophen 5-325 mg was missing between 05/19/25 and 06/12/25. 7. The controlled drug record for R #17’s hydrocodone-acetaminophen 5-325 mg was missing between 07/03/25 and 07/24/25. 8. The controlled drug record for R #24’s oxycodone-acetaminophen 5-325 mg was missing between 06/10/25 and 07/15/25. 9. He was not aware that the controlled drug records were missing for R #17 and R #24 until the surveyors requested documentation. 10. He stated he couldn’t find the Controlled Drug Record to reconcile the medications with the MAR’s. R #25 K. Record review of R #25’s admission Record, no date revealed R #25 was admitted to the facility on [DATE]. L. Record review of R #25’s physician orders revealed an order dated 06/30/25, for Oxycodone HCl Tablet 5 MG (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. M. Record review of the Controlled Drug Record revealed R #25’s Oxycodone HCl Tablet 5 MG dated 05/6/25 to 07/1/25 revealed missing pages of the record. N. On 08/21/25 at 2:24 PM, during an interview with the DON, he stated there was missing Controlled Drug Record sheets for R #25’s Oxycodone dated 05/06/25-07/01/25. R #27 O. Record review of R #27’s admission Record, no date revealed R #27 was admitted to the facility on [DATE]. P. Record review of R #27’s physician orders revealed the following: 1. Order dated 07/09/25, for Oxycodone HCl 5mg (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 6 hours as needed for pain. 2. Order dated 07/30/25, for Oxycodone HCl 5mg (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 4 hours as needed for pain. Q. Record review of R #27’s MAR dated July 2025 revealed staff documented R #27 was administered the following: 1. Oxycodone every 6 hours; a. On 07/21/25 at 3:50 AM. (continued on next page)

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	325047	A. Building B. Wing	08/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 07/27/25 at 2:00 PM. 2. Oxycodone every 4 hours; a. On 08/01/25 at 7:03 AM. b. On 08/02/25 at 1:15 PM. R. Record review of R #27’s Controlled Drug Record for Oxycodone HCl 5mg dated July 2025 revealed staff did not document the following: 1. Oxycodone every 6 hours; a. On 07/21/25 at 3:50 AM. b. On 07/27/25 at 2:00 PM. 2. Oxycodone every 4 hours; a. On 08/01/25 at 7:03 AM. b. On 08/02/25 at 1:15 PM. S. On 08/21/25 at 2:24 PM, during an interview with the DON, he stated there was missing documentation on R #27’s Controlled Drug Record sheets for Oxycodone.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for 2 (R #3 and R #18) of 3 (R #3, R #17, and R #18) residents reviewed for medication administration when staff failed to: 1. Ensure narcotic (a substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine but are not made from opium) medications were not administered earlier than ordered for R #3. 2. Ensure R #18 did not receive narcotic medication at a higher dose than ordered. This deficient practice is likely to result in a residents having adverse effects (unwanted, harmful, or abnormal result). The findings are: R #3 A. Record review of R #3's admission record (no date) revealed the following: 1. R #3 was admitted to the facility on [DATE]. 2. R #3 had the diagnosis of Chronic Pain (long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition). B. Record review of R #3's physician's orders revealed an order dated 10/11/25 for oxycodone-acetaminophen (combination medication used to help relieve moderate to severe pain) 10-325 mg, give one tablet by mouth every six hours as needed for chronic pain. C. Record review of R #3's Controlled Drug Record (mandatory documentation required by the Drug Enforcement Agency (DEA) to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) for oxycodone-acetaminophen 10-325 mg dated 10/24/25 to 11/10/25 revealed the following: 1. Staff signed out one tablet of oxycodone-acetaminophen 10-325 mg on 11/05/25 at 8:00 PM. 2. Staff signed out one tablet of oxycodone-acetaminophen 10-325 mg on 11/05/25 at 11:26 PM. D. Record review of R #3's MAR, dated November 2025, revealed the following: 1. Staff documented administration of oxycodone-acetaminophen 10-325 mg on 11/05/25 at 8:00 PM. 2. Staff did not document administration of oxycodone-acetaminophen 10-325 mg on 11/05/25 at 11:26 PM. E. On 11/14/25 at 11:15 AM, during an interview, the DON confirmed the following: 1. Staff administered R #3's oxycodone-acetaminophen 10-325 mg sooner than every six hours when they administered a dose at 8:00 PM on 11/05/25 then again at 11:26 PM on 11/05/25. 2. The administration of R #3's oxycodone-acetaminophen 10-325mg given prior to every six hours was a medication error. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #18 F. Record review of R #18's admission documents, no date, revealed the following: 1. R #18 was admitted to the facility on [DATE]. 2. R #18 had the following diagnoses: a. Low back pain (pain between the lower edge of the ribs and the buttock). b. Chronic pain. c. Migraine (a recurrent throbbing headache that typically affects one side of the head and is often accompanied by nausea and disturbed vision). G. Record review of R #18's physician's orders, dated 11/09/25, revealed an order for oxycodone 5 tablets, give two (2) tablets every 6 hours as needed for pain. H. Record review of R #18's Controlled Drug Record for oxycodone 5 mg, dated 10/18/25 to 11/10/25, revealed the following: 1. On 11/10/25 at 5:50 AM, staff documented removing two (2) tablets of oxycodone. 2. On 11/10/25 at 6:02 AM, staff documented removing one (1) tablet of oxycodone (resident had just received two (2) tablets 12 minutes before). I. On 11/14/25 at 10:23 AM, during an interview, NP #16 stated that a resident receiving more oxycodone than ordered would be considered a significant medication error. J. On 11/14/25 at 12:04 PM, during an interview, the DON confirmed the following: 1. Administering 5 mg of oxycodone within 12 minutes of the previous dose would have been a medication error. 2. The DON was not notified that R #18 had received more oxycodone than ordered on 11/10/25.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 6 (R #16, R #17, R #18, R #24, R #25, and R #27) of 6 (R #16, R #17, R #18, R #24, R #25, and R #27) residents reviewed for misappropriation of property when staff failed to: 1. Document narcotic medication administration on the MAR for R #16, R #17, R #18, R #24, R #25, and R #27. 2. Ensure R #16's order on his controlled drug record matched the order. These deficient practices have 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: R #16 A. Record review of R #16’s admission record, no date, revealed R #16 was admitted to the facility on [DATE]. B. Record review of R #16’s admission MDS, dated [DATE], revealed the following: 1. R #16 had a BIMS of 15. 2. R #16 had pain that was being treated with PRN pain medication. 3. R #16 was receiving opioid (sometimes called narcotics, are a type of drug. They include strong prescription pain relievers such as oxycodone, hydrocodone, fentanyl, and tramadol) pain medication. C. Record review of R #16’s physician’s orders, dated 05/28/25, revealed an order for hydrocodone-acetaminophen 7.5-325 mg (prescription medication used for the relief of moderate to moderately severe pain. It combines an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)) one tablet every four (4) hours as needed for moderate to severe pain (typically refers to a level on a pain scale that ranges from roughly 4 to 10 on a 0-10 scale, where a higher number indicates more intense pain). D. Record review of R #16’s Controlled Drug Record (mandatory documentation required by the DEA to track the complete life cycle of controlled substances, including their acquisition, administration, dispensing, and disposal. The purpose is to prevent diversion and ensure accountability for potentially addictive and illicitly traded drugs) for hydrocodone-acetaminophen 7.5-325 mg, dated 05/28/25 through 06/06/25, revealed the following administration dates and times: 1. Instructions for medication to be administered every six (6) hours PRN for pain (does not match order for every four (4 hours PRN). 2. 05/28/25 at 9:00 PM 3. 05/29/25 at 10:31 AM 4. 05/29/25 at 9:00 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. 05/30/25 at 1020 AM 6. 05/30/25 at 6:27 PM 7. 05/31/25 at 12:31 AM 8. 05/31/25 at 3:06 AM 9. 05/31/25 at 8:00 AM 10. 05/31/25 at 5:00 PM 11. 05/31/25 at 9:00 PM E. Record review of R #16’s MAR, dated May 2025, revealed the following administration for hydrocodone-acetaminophen 7.5-325 mg: 1. Staff did not document medication administration on 05/28/25 at 9:00 PM. 2. 05/29/25 at 10:31 AM. 3. Staff did not document medication administration on 05/29/25 at 9:00 PM. 4. 05/30/25 at 10:26 AM. 5. 05/30/25 at 6:27 PM. 6. Staff did not document medication administration on 05/31/25 at 12:31 AM. 7. 05/31/25 at 3:03 AM. 8. 05/31/25 at 10:43 AM (Does not match controlled drug record at 8:00 AM). 9. Staff did not document medication administration on 05/31/25 at 5:00 PM. 10. Staff did not document medication administration on 05/31/25 at 9:00 PM. R #17 F. Record review of R #17’s admission documents, no date, revealed R #17 was admitted to the facility on [DATE]. G. Record review of R #17’s quarterly MDS, dated [DATE], revealed the following: 1. R #17 had a BIMS of 15. 2. R #17 had pain that was being treated with PRN pain medication. 3. R #17 was receiving opioid pain medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #17’s physician order, dated 06/16/25, revealed an order for hydrocodone-acetaminophen 7.5-325 mg one tablet every six (6) hours as needed for moderate to severe pain (typically refers to a level on a pain scale that ranges from roughly 4 to 10 on a 0-10 scale, where a higher number indicates more intense pain). I. Record review of R #17’s Controlled Drug Record for hydrocodone-acetaminophen 7.5-325 mg, dated 07/03/25 through 07/13/25, revealed the following administration dates and times: 1. 07/03/25 at 9:27 AM 2. 07/03/25 at 5:41 PM 3. 07/03/25 at 10:49 PM 4. 07/04/25 at 3:00 AM 5. 07/04/25 at 8:30 AM 6. 07/04/25 at 4:32 PM 7. 07/04/25 at 9:30 PM 8. 07/05/25 at 2:30AM 9. 07/05/25 at 12:56 PM 10. 07/05/25 at 6:30 PM 11. 07/05/25 at 10:30 PM 12. 07/06/25 at 10:52 AM 13. 07/06/25 at 5:00 PM 14. 07/06/25 at 11:00 PM 15. 07/07/25 at 10:15 AM 16. 07/07/25 at 5:41 PM 17. 07/08/25 at 9:28 AM 18. 07/08/25 at 6:06 PM 19. 07/09/25 at 2:00 AM 20. 07/09/25 at 6:40 PM 21. 07/09/25 at 11:00 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	22. 07/10/25 at 9:00 AM 23. 07/10/25 at 6:46 PM 24. 07/11/25 at 12:15 AM 25. 07/11/25 at 7:15 AM 26. 07/11/25 at 4:37 PM 27. 07/11/25 at 10:00 PM 28. 07/12/25 at 8:59 AM 29. 07/12/25 at 3:34 PM 30. 07/12/25 at 9:30 PM 31. 07/13/25 at 10:05 AM J. Record review of R #17’s MAR, dated July 2025, revealed the following administration times for hydrocodone-acetaminophen 7.5-325 mg and effectiveness of medication: 1. 07/03/25 at 9:27 AM 2. 07/03/25 at 5:41 PM 3. 07/03/25 at 10:44 PM 4. Staff did not document medication administration on 07/04/25 at 3:00 AM. 5. 07/04/25 at 8:33 AM 6. 07/04/25 at 4:31 PM 7. 07/04/25 at 9:23 PM 8. 07/05/25 at 2:38 AM 9. 07/05/25 at 12:56 PM 10. 07/05/25 at 6:31 PM 11. 07/06/25 at 2:29 AM (Late documentation from 07/05/25 at 10:30 PM). 12. 07/06/25 at 10:52 AM 13. 07/06/25 at 5:03 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Staff did not document medication administration on 07/06/25 at 11:00 PM. 15. 07/07/25 at 10:15 AM 16. 07/07/25 at 5:41 PM 17. 07/08/25 at 9:28 AM 18. 07/08/25 at 6:16 PM 19. Staff did not document medication administration on 07/09/25 at 2:00 AM. 20. 07/09/25 at 6:41 PM 21. 07/09/25 at 11:00 PM 22. 07/10/25 at 9:35 AM 23. 07/10/25 at 6:43 PM 24. 07/11/25 at 12:14 AM 25. 07/11/25 at 7:15 AM 26. 07/11/25 at 4:37 PM 27. 07/11/25 at 10:50 PM 28. 07/12/25 at 8:59 AM 29. 07/12/25 at 3:34 PM 30. Staff did not document medication administration on 07/12/25 at 9:30 PM. 31. 07/13/25 at 10:05 AM R #18 K. Record review of R #18’s admission documents, no date, revealed R #18 was admitted to the facility on [DATE]. L. Record review of R #18’s quarterly MDS, dated [DATE], revealed the following: 1. R #18 had a BIMS of 15. 2. R #18 had pain that required the use of PRN pain medication. 3. R #18 was receiving opioid pain medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Record review of R #18’s physician’s order, dated 06/14/25, revealed an order for oxycodone (a powerful opioid pain medication used to treat moderate to severe pain) 5 mg every four (4) hours as needed for pain level 6-10. N. Record review of R #18’s Controlled Drug Record for oxycodone 5 mg, dated 08/10/25 through 08/20/25, revealed the following administration dates and times: 1. 08/10/25 at 8:59 PM 2. 08/11/25 at 8:17 AM 3. 08/11/25 at 8:00 PM 4. 08/12/25 at 8:23 AM 5. 08/12/25 at 8:00 PM 6. 08/13/25 at 7:43 AM 7. 08/13/25 at 9:05 PM 8. 08/14/25 at 7:58 AM 9. 08/14/25 at 9:35 PM 10. 08/15/25 at 8:41 AM 11. 08/15/25 at 8:00 PM 12. 08/16/25 at 8:00 PM 13. 08/17/25 at 8:17 AM 14. 08/17/25 at 7:00 PM 15. 08/18/25 at 9:23 AM 16. 08/18/25 at 10:19 PM 17. 08/19/25 at 9:02 AM 18. 08/19/25 at 8:55 PM 19. 08/20/25 at 9:11 AM 20. 08/20/25 at 4:43 PM 21. 08/20/25 at 10:35 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. Record review of R #18’s MAR, dated August 2025, revealed the following administration times for oxycodone 5 mg and effectiveness of medication: 1. 08/10/25 at 9:53 PM 2. 08/11/25 at 8:17 AM 3. Staff did not document medication administration on 08/11/25 at 8:00 PM. 4. 08/12/25 at 8:23 AM 5. 08/12/25 at 8:00 PM 6. 08/13/25 at 7:43 AM 7. 08/13/25 at 9:07 PM 8. 08/14/25 at 7:58 AM 9. 08/14/25 at 9:32 PM 10. 08/15/25 at 8:41 AM 11. Staff did not document medication administration on 08/15/25 at 8:00 PM. 12. 08/16/25 at 8:00 PM 13. Staff did not document medication administration on 08/17/25 at 8:00 AM. 14. 08/17/25 at 8:00 PM 15. 08/18/25 at 9:16 AM 16. Staff did not document medication administration on 08/18/25 at 10:19 PM. 17. 08/19/25 at 9:03 AM 18. Staff did not document medication administration on 08/19/25 at 8:55 PM. 19. 08/20/25 at 9:11 AM 20. 08/20/25 at 4:43 PM 21. 08/20/25 at 10:36 PM P. On 08/21/25 at 12:24 PM, during an interview, CMA #17 stated that all narcotic medications should be documented on the controlled drug sheet and the resident’s MAR. Q. On 08/21/25 at 3:09 PM, during an interview, NP #16 stated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. She looks at the MAR to determine the resident’s usage of pain medications. 2. She does not look at the controlled drug records. 3. If staff don’t document in the MAR, she would not know how frequently the resident used pain medication and would not be able to accurately assess the resident’s pain management. R. On 08/21/25 at 11:19 PM, during an interview, the DON confirmed the following: 1. Staff were expected to document administration of all medication on the residents’ controlled drug record and the MAR. 2. He was not aware that R #18's controlled drug record for hydrocodone-acetaminophen 7.5-325 mg administration instructions did not match the order. 3. Staff were expected to ensure the controlled drug record medication administration instructions matched the resident’s orders. R #24 S. Record review of R #24’s Administration Record, no date revealed R #24 was admitted to the facility on [DATE]. T. Record review of R #24’s physician orders revealed an order dated 11/22/24, for Oxycodone-Acetaminophen 5-325mg (a combination pain-relief medication prescribed to treat acute moderate-to-severe pain), give 1 tablet by mouth every 4 hours as needed for pain. U. Record review of the Controlled Drug Record revealed R #24’s record for Oxycodone-Acetaminophen 5-325 dated 06/12/25 through 07/15/25 revealed three missing pages of the record. V. Record review of R #24’s Controlled Drug Record for Oxycodone-Acetaminophen 5-325 dated 07/16/25 through 08/18/25 revealed staff documented the following: 1. On 07/16/25 at 7:30 PM Oxycodone-Acetaminophen was documented as given. 2. On 07/17/25 at 8:45 PM Oxycodone-Acetaminophen. 3. On 07/23/25 at 8:53 PM and 11:00 PM Oxycodone-Acetaminophen. 4. On 07/24/25 at 12:51 AM, 4:00 AM, 10:14 AM, 6:30 PM, 11:00 PM Oxycodone-Acetaminophen. 5. On 07/25/25 at 8:41PM Oxycodone-Acetaminophen. 6. On 07/26/25 at 1:00 AM Oxycodone-Acetaminophen was documented as given twice. 7. On 08/04/25 at 9:30 PM Oxycodone-Acetaminophen. W. Record review of R #24’s MAR dated July 2025 revealed staff did not document the following: (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 07/16/25 at 7:30 PM Oxycodone-Acetaminophen. 2. On 07/17/25 at 8:45 PM Oxycodone-Acetaminophen. 3. On 07/23/25 at 8:53 PM and 11:00 PM Oxycodone-Acetaminophen. 4. On 07/24/25 at 12:51 AM, 4:00 AM, 10:14 AM, 6:30 PM, 11:00 PM Oxycodone-Acetaminophen. 5. On 07/25/25 at 8:41PM Oxycodone-Acetaminophen. 6. On 07/26/25 at 1:00 AM Oxycodone-Acetaminophen was not documented either dose. 7. On 08/04/25 at 9:30 PM Oxycodone-Acetaminophen. X. On 08/20/25 at 9:24 AM, during an interview with the DON, the DON stated he couldn’t find Controlled Drug Record to reconcile. The DON did confirm staff did not document in R #24’s MAR for the Oxycodone-Acetaminophen. R #25 Y. Record review of R #25’s Administration Record, no date revealed R #25 was admitted to the facility on [DATE]. Z. Record review of R #25’s physician orders revealed an order dated 06/30/25, for Oxycodone HCl Tablet 5 MG (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. AA. Record review of R #25’s Controlled Drug Record for Oxycodone HCl Tablet 5 MG dated 05/6/25 through 07/1/25 revealed three missing pages of the record. BB. On 08/21/25 at 2:24 PM, during an interview with the DON, he stated there was missing Controlled Drug Record sheets for R #25’s Oxycodone dated 05/06/25-07/01/25. CC. Record review of R #27’s Administration Record, no date revealed R #27 was admitted to the facility on [DATE]. DD. Record review of R #27’s physician orders revealed the following: 1. Order dated 07/09/25, for Oxycodone HCl 5mg (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 6 hours as needed for pain. 2. Order dated 07/30/25, for Oxycodone HCl 5mg (is a prescription medicine used to treat moderate to severe pain), give 1 tablet by mouth every 4 hours as needed for pain. EE. Record review of R #27’s MAR dated July 2025 revealed staff documented R #27 was administered the following: 1. Oxycodone every 6 hours; (continued on next page)

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	08/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 07/21/25 at 3:50 AM. b. On 07/27/25 at 2:00 PM. 2. Oxycodone every 4 hours; a. On 08/01/25 at 7:03 AM. b. On 08/02/25 at 1:15 PM. FF. Record review of R #27’s Controlled Drug Record for Oxycodone HCl 5mg dated July and August 2025 revealed staff did not document the following: 1. Oxycodone every 6 hours; a. On 07/21/25 at 3:50 AM. b. On 07/27/25 at 2:00 PM. 2. Oxycodone every 4 hours; a. On 08/01/25 at 7:03 AM. b. On 08/02/25 at 1:15 PM. GG. On 08/21/25 at 2:24 PM, during an interview with the DON, he stated there was missing documentation on R #27’s Controlled Drug Record sheets for the following: 1.Oxycodone every 6 hours; a. On 07/21/25 at 3:50 AM. b. On 07/27/25 at 2:00 PM. 2. Oxycodone every 4 hours; a. On 08/01/25 at 7:03 AM. b. On 08/02/25 at 1:15 PM.