

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Casa Del Sol Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2905 East Missouri Avenue Las Cruces, NM 88011	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation and interview, the facility failed to provide reasonable accommodation of resident needs for 2 (R #2 and R #3) of 2 (R #2 and R #3) residents reviewed for mobility throughout the facility when the facility failed to ensure that the ramp to the outdoor gazebo was accessible to residents who use wheelchairs and/or walkers. This deficient practice could result in frustration or making the residents feel like their feelings don't matter, leaving them at risk of accidents and falls, and feeling unimportant. The findings are: R #2 A. On 09/09/25 at 10:35 AM, during an observation and interview of R #2, she sat on the seat of her front wheel walker. R #2 stated there has been medical equipment left on the ramp of the outdoor gazebo, and she cannot use the ramp because it is not wide enough for the equipment and her walker to fit. R #3 B. On 09/09/25 at 10:42 AM, during an interview, R #3 stated she has also seen medical equipment placed on the gazebo. She uses a wheelchair and cannot use the ramp because her wheelchair does not fit when there is medical equipment on the ramp. C. On 09/09/25 at 10:50 AM, during an observation of the outdoor gazebo, a white Polyvinyl chloride (PVC; a lightweight, durable material) shower chair (used to shower residents with mobility issues) was at the top of the ramp where one would get onto the gazebo. D. On 09/09/25 at 4:00 PM, during an observation of the outdoor gazebo, the PVC shower chair was still on the ramp to the gazebo. E. On 09/10/25 at 3:16 PM, during an observation of the outdoor gazebo, the PVC shower chair was still on the ramp to the gazebo. F. On 09/10/25 at 3:16 PM, during an interview with the maintenance director, he stated he was unsure why the shower chair was placed on the ramp. He stated it is not supposed to be placed there and he would move it.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews, the facility failed to meet professional standards of practice for 1 (R #1) of 3 (R #1, R #2 and R #3) residents reviewed for physician's orders when staff failed to collect a urinalysis sample (urine sample sent to laboratory for testing) as ordered. If the facility is not completing physician's orders and providing care that meets professional standards of practice, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: A. Record review of R #1's admission Record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had the following diagnoses: a. Fracture of the lower end of left femur (broken thigh bone, area closest to the knee). b. Generalized muscle weakness (lack of muscle strength throughout the body). c. Pain in left hip. d. Repeated falls. B. Record review of R #1's physician orders revealed an order dated 04/24/25: Please collect urinalysis/culture and sensitivity (laboratory test that determines the best antibiotic to treat an infection), please collect from Foley tube (clear plastic tube that drains urine from bladder into a collection bag) not bag. C. Record review of R #1's treatment administration record (TAR; a form used to document completion of treatments), dated April 2025, revealed staff documented the urine sample was collected 04/25/25. D. Record review of R #1's medical record revealed there was no urinalysis/culture and sensitivity test lab results. E. On 09/10/25 at 3:33 PM during an interview, the unit manager confirmed the following: 1. There are no results on file for the urinalysis/culture and sensitivity. 2. She was unaware the urinalysis had not been collected. 3. She called the laboratory on 09/10/25 and the lab advised her the urine sample was never received for processing.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation and interview, the facility failed to assure medications were secured and inaccessible to unauthorized staff, visitors, and residents. This deficient practice has the potential to affect all 14 residents residing on the 300 hall as identified on the resident census provided by the Administrator on 09/08/25. Improperly stored medications could result in a resident, staff member, or visitor taking the medications not prescribed to them. The findings are: A. On 09/09/25 at 8:52 AM, during a random observation of the 300 hall revealed a medication cart in the hallway, the medication cart was unlocked. Staff were not present in the area near the cart. B. On 09/09/25 at 9:01 AM, the unit manager was in the 300 hall. She confirmed the cart was unlocked, and she stated the medication carts should be locked when unattended.</p>		