STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Care Center	635 Harkle Road Santa Fe, NM 87505

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to revise and update the care plan for 1 (R #1) of 1 (R #1) residents reviewed for unwitnessed injuries. If the facility is not updating the care plan to reflect the resident's current care needs and treatments, then the facility may not be providing the appropriate care to meet the resident's needs. The findings are: A. Record review of R #1 face sheet, dated 07/02/24, revealed he was admitted to the facility on [DATE] with multiple diagnoses including: - Vascular dementia (a chronic decline in mental abilities and memory) with behaviors. - Major depression (overwheliming sadness). - Late onset cerebelar (a portion of the brain) ataxia (impaired muscular movements). - Cognitive communication deficits (difficulty in speech and language). B. Record review of R #1's daily care notes, dated 05/21/24, revealed R#1 had a bluish discoloration around his left second finger and fourth finger. C. Record review of R #1's Nurses Skin Check, dated 05/20/24, revealed R#1 had discoloration of right and left hands. D. On 07/02/24 at 4:15 pm during interview with Registered Nurse (RN) #1, she stated R #1 had bruises on his right and left hands. She stated the R#1's daughter brought the bruises to the attention of staff, and they began an investigation to consider the possible cause of the bruises. RN #1 stated the nurses and physical therapy observed R #1 grab the wheels of his wheelchair in such a way that he caused bruising to his hands. RN #1 stated staff were to provide total assistance to the resident, to include propelling his wheelchair when he wanted to move about the facility. RN #1 reviewed R#1's care plan and stated R #1's care plan did not contain information regarding his wheelchair use. E. Record review of R #1's care plan, dated 07/02/24, revealed the care plan did not mention staff to provide total assistance for R #1 when he used his wheelchair.

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