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	10/25/2024

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to notify the Providers (Physicians and Nurse Practitioners) and the Director of Nursing (DON) of a change in condition in which a resident experienced a large left forearm injury (skin tear- acute wound that is caused by mechanical force or a traumatic injury) for 1 (R #4) of 1 (R #4) residents reviewed for injury. This deficient practice likely resulted in R #4's injury becoming worse with increased bleeding due to the resident taking a blood thinner, and a delay going to the hospital. The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] and was discharged on [DATE]. B. Record review of R #4's care plan, dated 07/09/24, revealed R #4 experienced confusion, balance problems, vision and hearing problems; and R #4 was unaware of safety needs. C. Record review of R #4's physician orders, dated 07/09/24, revealed R #4 was prescribed apixaban (blood thinner), 5 milligrams (mg) twice a day, which was started on 07/09/24. D. Record review of R #4's Medication Administration Record (MAR), dated 09/01/24 through 09/09/24, revealed staff administered apixaban to R #4 twice a day, every day. E. Record review of R #4's nursing progress notes revealed the following: 1. Dated 09/09/24 at 6:10 am and written by Registered Nurse (RN) #1, a Certified Nursing Assistant (CNA) and an RN found R #4 at 6:00 am. The resident showed signs of confusion and required help changing into daily clothes. The RN discovered a large gash (skin tear/laceration) on R #4's left forearm that appeared to be self-inflicted, and the CNA and RN dressed the resident's wound. Assessment: R #4's wound measured 4 inches (in) length and 1.5 in. width. The RN reported R #4's injury to the oncoming RN, Director of Nursing (DON), and the Provider. 2. Dated 09/09/24 at 7:30 pm and written by RN #1, the deep tissue wound on R #4's left forearm (previously noted at 6:10 am as a large gash) bled profusely. R #4 was sent to the emergency room (ER). (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
	325030	A. Building B. Wing	10/25/2024

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 0580 Level of Harm - Actual harm Residents Affected - Few	3. Staff did not document any other progress notes between 6:00 am and 7:30 pm for R #4's left forearm injury, which indicated the facility's nursing staff did not assess R #4 again throughout the day and did not contact a provider or the DON to inform them of R #4's wound. D. Record review of R #4's ER documentation, dated 09/09/24 at 7:44 pm, revealed the following: 1. Left forearm laceration: Brought in by Emergency Medical Services (EMS) and laceration was found by nursing home nurse at 7:00 am. 2. Left forearm: Large skin tear (a type of injury where the skin is torn from the body) with painful range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point). Left forearm does have some full thickness flap loss [deep wounds that extend beyond the first two layers of the skin and may reveal subcutaneous (fatty) tissue, muscle, tendon, or even bone.] E. On 10/10/24 at 12:14 pm during an interview with RN #1, he stated a CNA asked him to assist with R #4 prior to shift change on the morning of 09/09/24. RN #1 stated he noticed R #4 was confused and had a large laceration on her left forearm that was actively bleeding, which required a bandage. RN #1 stated he informed the day shift nurse of R #4's injury that morning after he bandaged and wrapped R #4's left forearm. RN #1 stated that when he returned to shift later that evening on 09/09/24, he had to send R #4 to the ER due to R #4's left forearm injury (large gash noted at 6:10 am) became worse throughout the day. RN #1 stated R #4's left forearm still had the original bandage that he applied earlier that day and R #4's left forearm bandage was completely saturated with blood, indicating R #4's left forearm was still actively bleeding which required him to send R #4 to the hospital. RN #1 also confirmed the day shift did not document that they assessed R #4's laceration during their shift, and he notified the Director of Nursing (DON) and provider when he arrived for his night shift that R #4 required hospitalization . F. On 10/11/24 at 11:07 am during an interview with the Nurse Practitioner (NP), she stated the facility staff did not notify her about R #4's left forearm laceration on 09/09/24, but they should have. The NP confirmed that due to the size and severity of R #4's left forearm injury, the NP should have been notified immediately, so she could assess R #4's left forearm, provide additional treatment such as a topical ointment to clean the wound and stop bleeding, and advise nursing staff to send R #4 to the hospital right away. The NP confirmed her expectation was for nursing staff to notify her as soon as possible when residents experience a significant injury like R #4 did. G. On 10/11/24 at 12:30 pm during an interview with the DON, she stated she was not aware of R #4's left forearm injury on 09/09/24 until R #4 was sent her the hospital at 7:00 pm on 09/09/24. The DON confirmed it was her expectation for nursing staff to notify the facility providers and herself right away when a resident experienced a significant injury like R #4.

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	10/25/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41988 Based on record review and interview, the facility failed to report an investigation regarding allegations of an injury of unknown origin for 1 (R #4) of 1(R #4) residents reviewed for injuries and wounds. If the facility is not submitting the summary of the facility's investigation to the State Agency, then the State Agency is unable to appropriately triage (review) the allegation for further investigation. The findings are: A. Refer to F684 for pertinent findings related to this citation. B. On 10/25/24 at 2:25 pm during an interview with the Director of Nursing (DON), she stated she spoke to Registered Nurse (RN) #2 about the incident. She stated she did not conduct a complete investigation, because she felt like she did not need to after speaking with RN #2. The DON also stated that she completed a unit investigation for multiple residents that involved RN #1 (RN involved in R #4 incident), but she did not specifically include R #4 and she should have. C. On 10/25/24 at 2:39 pm during an interview with the Administrator (ADM), he stated he did not complete an investigation for the resident's injury, because the Director of Nursing (DON) investigated the whole unit that R #4 was on for another incident, but that investigation did not specifically include R #4. The ADM confirmed that R #4 should have been included in a investigation and was not.

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	10/25/2024

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** 41988 Based on record review and interview, the facility failed to ensure staff revised the care plan for 1 (R #4) of 1 (R #4) residents reviewed when staff failed to update the care plan to include anticoagulant (blood thinner) use. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] and was discharged on [DATE]. B. Record review of R #4's physician orders, dated 07/09/24, revealed an order for apixaban (blood thinner), 5 milligrams (mg) twice a day. C. Record review of R #4's care plan revealed the following: - Dated 07/09/24, R #4 was a risk for falls due to R #4 experienced confusion, balance problems, vision and hearing problems; and R #4 was unaware of safety needs. - The care plan did not include information regarding R #4's order for apixaban. D. On 10/25/24 at 2:27 pm during an interview with the Director of Nursing (DON), she stated staff should have care planned R #4's anticoagulant use, but they did not.

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	10/25/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, nail care, and eating) assistance for toenail care by the facility staff for 1 (R #4) of 1 (R #4) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] and was discharged on [DATE]. B. Record review of R #4's care plan, dated 07/09/24, revealed R #4 required staff assistance with ADL care related to Alzheimer's disease (type of brain disorder that causes problems with memory, thinking and behavior), fatigue, impaired balance, and limited mobility. C. Record review of R #4's skin/bathing completion form, dated 08/12/24 through 09/11/24, revealed staff trimmed and cleaned R #4's toenails twice. D. Record review of R #4's emergency room (ER) clinical notes dated 09/16/24 revealed R #4's toenails were long and required trimming by hospital staff, so R #4 could have better mobility. E. On 10/09/24 at 1:42 pm during an interview with R #4's Power of Attorney (POA), she stated facility staff did not care for R #4's toenails, and she brought that up to the facility staff multiple times. F. On 10/11/24 at 11:41 am during an interview with Certified Nursing Assistant (CNA) #3, she stated staff document all toenail care on the skin/bathing completion forms. CNA #3 also stated she received a complaint from R #4's family about R #4's nail care, and the facility social worker also told her R #4's family complained about R #4's nail care. CNA #3 stated she completed R #4's nail care after receiving the complaint, but R #4's toenails looked like they were not tended to in quite some time. G. On 10/11/24 at 12:32 pm during an interview with the Director of Nursing (DON), she stated she expected CNAs to check residents' toenails during each shower, clean them, and trim them as needed. The DON confirmed R #4's toenails were not cared for as expected, but they should have been.

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	10/25/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to monitor and provide appropriate interventions for 1 (R #4) of 3 (R #4, #5, and #6) residents reviewed for injury: 1. When the facility failed to provide proper wound care for R #4's left forearm laceration. 2. When the facility nurses failed to communicate the severity of R #4's left forearm laceration to other nursing staff. 3. When the facility failed to re-assess R #4's left forearm laceration for approximately 12 hours. These deficient practices likely resulted in R #4's left forearm laceration becoming worse with additional bleeding, that required hospitalization . The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] and was discharged on [DATE]. B. Record review of R #4's care plan, dated 07/09/24, revealed R #4 experienced confusion, balance problems, vision and hearing problems; and R #4 was unaware of safety needs. C. Record review of R #4's physician orders, dated 07/09/24, revealed R #4 was prescribed apixaban (blood thinner), 5 milligrams (mg) twice a day, which was started on 07/09/24. D. Record review of R #4's Medication Administration Record (MAR), dated 09/01/24 through 09/09/24, revealed staff administered apixaban to R #4 twice a day, every day. E. Record review of R #4's nursing progress notes revealed the following: 1. Dated 09/09/24 at 6:10 am and written by Registered Nurse (RN) #1, a Certified Nursing Assistant (CNA) and an RN found R #4 at 6:00 am. The resident showed signs of confusion and required help changing into daily clothes. The RN discovered a large gash (skin tear/laceration) on R #4's left forearm that appeared to be self-inflicted, and the CNA and RN dressed the resident's wound. Assessment: R #4's wound measured 4 inches (in) length and 1.5 in. width. The RN reported R #4's injury to the oncoming RN, Director of Nursing (DON), and the Provider. 2. Dated 09/09/24 at 7:30 pm and written by RN #1, the deep tissue wound on R #4's left forearm (previously noted at 6:10 am as a large gash) bled profusely. R #4 was sent to the emergency room (ER). 3. Staff did not document any other progress notes between 6:00 am and 7:30 pm for R #4's left forearm injury, or any evidence that the facility's nursing staff assessed R #4 throughout the day. (continued on next page)

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	10/25/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	F. Record review of R #4's Electronic Health Record (EHR) revealed staff completed one change in condition assessment for R #4 on 09/10/24, which revealed R #4 was sent to hospital on 09/09/24 at approximately 7:00 pm for a laceration to the left forearm. G. Record review of R #4's ER documentation, dated 09/09/24 at 7:44 pm, revealed the following: 1. Left forearm laceration: Brought in by Emergency Medical Services (EMS) and laceration was found by nursing home nurse at 7:00 am. 2. Left forearm: Large skin tear (a type of injury where the skin is torn from the body) with painful range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point). Left forearm had some full thickness flap loss [deep wounds that extend beyond the first two layers of the skin and may reveal subcutaneous (fatty) tissue, muscle, tendon, or even bone.] H. On 10/09/24 at 1:40 pm during an interview with R #4's Power of Attorney (POA), she stated she was notified on the evening of 09/09/24 that R #4 experienced a laceration (a wound produced by tearing) to her left forearm earlier in the day. She stated staff reported the laceration was bleeding profusely and required R #4 to go to the hospital. R #4's POA also stated the nurse told her that staff did not tend to R #4's left forearm laceration throughout the day, and the laceration became worse during that time, with increased bleeding and pain. I. On 10/10/24 at 12:14 pm during an interview with RN #1, he stated a CNA asked him to assist with R #4 prior to shift change on the morning of 09/09/24. RN #1 stated he noticed R #4 was confused and had a large laceration on her left forearm that was actively bleeding, which required a bandage. RN #1 stated he informed the day shift nurse of R #4's injury that morning after he bandaged and wrapped R #4's left forearm. RN #1 stated that when he returned to shift later that evening on 09/09/24, he had to send R #4 to the ER due to R #4's left forearm injury (large gash noted at 6:10 am) became worse throughout the day. RN #1 stated R #4's left forearm still had the original bandage that he applied earlier that day and R #4's left forearm bandage was completely saturated with blood, indicating R #4's left forearm was still actively bleeding which required him to send R #4 to the hospital. RN #1 also confirmed the day shift did not document that they assessed R #4's laceration during their shift, and he notified the Director of Nursing (DON) and provider when he arrived for his night shift that R #4 required hospitalization . J. On 10/11/24 at 11:04 am during an interview with the Nurse Practitioner (NP), she stated it was the nurses' jobs to assess all facility residents everyday. The NP stated R #4's left forearm injury was very large and noticeable, and the day shift nurses (on 09/09/24) should have re-assessed it instead of waiting for the night shift nurses to do it. The NP confirmed that due to the size and severity of R #4's left forearm injury, the NP should have been notified immediately so she could assess R #4's left forearm, provide additional treatment such as a topical ointment to clean the wound and stop bleeding, and advise nursing staff to send R #4 to the hospital right away. (continued on next page)

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	10/25/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	K. On 10/11/24 at 11:20 am during an interview with RN #2 [day shift nurse on 09/09/24], she stated RN #1 did not tell her about R #4's left forearm laceration on 09/09/24 when she began her day shift. RN #2 stated she did not see R #4's left forearm laceration on 09/09/24, so she did not re-assess R #4's arm throughout her shift. RN #2 confirmed she did not see R #4's injury until R #4 returned from the hospital. RN #2 stated, If he [RN #1] had noticed everything [with R #4's laceration], then he [RN #1] should have taken care of it [fully assessed R #4's left forearm injury, provided complete documentation for R #4's left forearm injury, notified the provider of R #4's left forearm injury, and sent R #4 to the hospital before he left the facility]. L. On 10/11/24 at 11:25 am during an interview with the Wound Care Nurse (WCN), she stated RN #2 did not tell her about R #4's left forearm laceration during the day shift on 09/09/24. The WCN stated RN #2 told her that RN #1 did not tell her about R #4's laceration either. The WCN confirmed she was not made aware of R #4's laceration until R #4 returned from the hospital on 09/10/24. M. On 10/11/24 at 11:32 am during an interview with RN #3, he stated the facility nurses should make a point to see every one of their assigned residents at least once throughout the shift. RN #3 also stated it was expected for nurses assess each of their residents every shift. N. On 10/11/24 and 11:55 am during an interview with CNA #2, he stated he saw R #4's left forearm laceration during the day shift on 09/09/24, because R #4's left forearm injury/skin tear was large with significant bruising, and blood was present on the bandages. CNA #2 stated he informed RN #2 of R #4's laceration, but RN #2 told him that RN #1 had already made her aware of the laceration during shift change. CNA #2 confirmed that he did not see RN #2 assess R #4's left forearm injury throughout the shift. O. On 10/11/24 at 12:28 pm during an interview with the Director of Nursing (DON), she stated RN #1 told her [DON] that he informed RN #2 of R #4's laceration during shift change, but RN #2 told her RN #1 did not report it to her [RN #2]. The DON stated RN #2 did not re-assess R #4 during the day shift, and RN #2 should have. The DON stated it was her expectation the facility nurses assess each one of their residents on every shift. P. On 10/25/24 at 12:38 pm during an interview with CNA #1, she stated R #4 did not have any injuries present when she assisted and changed R #4 on the night shift (09/08/24). CNA #1 stated R #4 needed the assistance of one staff for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). She stated R #4 was more agitated than normal on 09/09/24 between 5:00 am and 5:30 am, and the resident grabbed at herself and CNA #1. CNA #1 then stated that after R #4 became agitated, she requested that RN #1 help her get R #4 dressed. CNA #1 stated that she briefly left R #4's room to answer a nearby call light and when she returned, approximately 5 to 10 minutes after RN #1 arrived to assist with R #4, she noticed that R #4 had a large skin tear on her left arm. RN #1 told her that R #4 did it to herself. CNA #1 stated RN #1 bandaged R #4's wound, but he did not clean it. CNA #1 stated she and RN #1 took R #4 out to the main lobby after the injury occurred where other staff and residents were present. CNA #1 also confirmed that she saw RN #1 go to the nurses station after that, but she did not know if RN #1 informed the day shift nurse of the incident. (continued on next page)

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	10/25/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Q. On 10/25/24 at 1:35 pm during an interview with CNA #4, she stated she worked during the day shift on 09/09/24, and she was not aware of R #4's left arm injury. CNA #4 stated usually the nurse would let her know if a resident experienced an injury like that but RN #2 did not inform her. CNA #4 confirmed she saw R #4 during the shift, and R #4 was wearing a long shirt with bandaging on her arm, but she did not know why and she did not look at R #4's left forearm. R. On 10/25/24 at 2:25 pm during an interview with the DON, the DON stated that RN #1 should have properly dressed R #4's left arm injury on 09/09/24 and communicated the severity of R #4's left forearm injury with staff.

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	10/25/2024

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 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. 39509 Based on record review and interview, the facility failed to ensure resident medical records were complete and accurate for 3 (R #1, #2 and #3) of 3 (R #1, #2 and #3) residents reviewed. This deficient practice will likely result in staff not knowing residents' daily care events, changes, and needs. The findings are: Resident #1 A. Record review of R #1 face sheet, dated 10/09/24, revealed he was admitted to facility on 06/17/24 with multiple diagnoses including: - Chronic pain due to trauma (injury), - Amputation of one right lesser toe (small toe of right foot), - Diabetes mellitus (a chronic condition in which the blood's sugar levels are not properly controlled by natural processes), - Malignant neoplasm (cancerous tumor) of prostate (male reproductive gland). B. On 10/09/24 at 2:20 pm during phone interview with Home Health Nurse (HHN) # 1, she stated the Home Health provider (a service that provides in home nursing and daily living care) required all patients to be weight bearing (able to bear weight on their feet.) She stated R #1's weight bearing status should have been included in his medical record. HHN stated that when she met with R #1 in his home, she found him lying on his couch, unable to stand or walk, because he was not weight bearing. HHN stated that if she had known R #1 was unable to bear weight, then he would not have been accepted into the home health program. C. On 10/09/24 at 3:25 pm during phone interview with R #1, he stated he was discharged from the facility on 10/01/24. He stated he was referred to and accepted into a Home Health provider when he was discharged from the facility. He stated he was mostly bed bound while a resident at the facility, and he needed staff assistance to sit up in bed, transfer to his wheelchair, and transfer back to bed. He stated he was never able to stand up and place weight on either of his feet while at the facility. D. Record review of R #1 daily nursing/medical care notes, dated 06/08/24 to 10/09/24, revealed the record did not contain any notations the resident was bed bound and unable to stand, walk, or move about while a resident. The record also did not include any notations to indicate the resident was non-weight bearing. E. Record review of R #1 care plan, dated 10/09/24, revealed multiple care plans, but none indicated R #1 was bed bound, unable to stand, unable to walk, or non-weight bearing. (continued on next page)

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	10/25/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 10/10/24 at 10:35 am during interview and record review with Social Services Coordinator (SSC), she stated she was the person who sent out documentation of R #1's referral to Home Health, and she sent it out via fax three days prior to his discharge. The SSC reviewed the documents she sent for R #1's referral and confirmed the record did not include or indicate R #1's weight bearing status. Resident #2 G. Record review of R #2 face sheet, dated 10/10/24, revealed she was admitted to facility on 08/16/24 with multiple diagnoses including: - Diabetes mellitus, - Emphysema (a respiratory disorder that results in the reduction of air intake), - Acute pulmonary edema (a sudden condition when the lungs become fluid filled), - COVID 19 (a viral respiratory disease). H. On 10/09/24 at 1:31 pm during phone interview with R #2's daughter, she stated her mother had been a resident of the facility. She stated one day her mother began to have difficulty breathing and was sent to hospital emergency room for evaluation. She stated her mother was admitted , tested positive for COVID 19, was treated, and returned to the facility. I. Record review of R #2's complete medical record revealed her daily care notes failed to report a time when she had difficulty breathing, any time she was transferred to hospital, and any time when she returned from hospital. Her medical record did not contain a report of a change of condition (a nursing note to indicate a significant medical change in a resident's medical status) to indicate the resident had difficulty breathing and was sent to hospital. J. On 10/10/24 at 1:49 pm during interview and record review with the Director of Nursing (DON), she stated R #2 was sent to hospital and returned. She reviewed R #2's medical record and confirmed the resident's transfer and return were not documented in the medical record. The DON stated staff should have documented several notes regarding the resident's breathing problems, transfer to hospital, change of condition, and return to the facility. Resident #3 K. Record review of R #3's face sheet, dated 10/10/24, revealed he was admitted to facility on 09/04/24 with multiple diagnoses including: - History of falling, - Myelodysplastic syndrome (a type of cancer of the blood) - Morbid obesity (severely overweight), - Monoplegia (paralysis of one limb) of right upper limb, (continued on next page)

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	10/25/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- discharged from the facility on 09/19/24. L. Record review of daily care note, dated 09/19/24 revealed a entry which stated R #3 expressed ideas of suicide. Staff offered the resident care, and he refused. R #3 became verbally aggressive and stated he wanted to kill staff. The facility issued R #3 an immediate discharge notice, and the resident was sent to the hospital with his personal items. M. On 10/10/24 at 2:30 pm during interview with DON and Administrator (ADM), they stated R #3 had multiple incidents of refusing care, threatening staff, vomiting on staff, throwing vomit on another resident, and using racial slurs aimed at staff and other residents. N. Record review of R #3's daily care notes, dated 09/04 to 09/19/24 revealed the following: -09/05/24 Refused wound care and described the wound care nurse as a stupid, crazy Indonesian wound nurse who knows nothing, and she can't even speak english. -09/10/24 Described as mood is pleasant, no behaviors witnessed. -09/11/24 Described as mood is pleasant, no behaviors witnessed. -09/12/24 Described as mood is pleasant, no behaviors witnessed. -09/14/24 Described as mood is pleasant, no behaviors witnessed. -09/15/24 Described as mood is pleasant, no behaviors witnessed. -09/17/24 Described as mood is pleasant, no behaviors witnessed. -09/18/24 Described as mood is pleasant, no behaviors witnessed. -09/18/24 Refused to attend an appointment. -09/19/24 Refused to allow wound care There are no notes that document any instances of R #3 threatening staff, vomiting on staff, throwing vomit on another resident. O. On 10/10/24 at 2:45 pm during interview with ADM, he stated staff should have noted the resident's behavior in R #3's medical record. He stated he did not know why staff did not document the reported events in R #3's medical record.