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	11/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect the residents from the potential for accidents and hazards for 2 (R #s 24 and 71) of 2 (R #s 24 and 71) residents reviewed for falls when the facility did not provide fall mats as ordered by a physician and/or care planned. If the facility is not using fall mats for residents' safety as ordered by a physician, then this deficient practice could likely result in residents getting injured in avoidable accidents and putting residents at risk of serious injury, serious harm, and possibly death. The findings are: R #24: A. Record review of R #24's face sheet revealed R #24 was admitted into the facility on [DATE]. B. Record review of R #24's care plan dated 11/18/25 revealed R #24 was a high risk for falls related to confusion, gait/balance problems, and paralysis (the loss of the ability to move). Staff interventions included a fall mat to be present when R #24 was in bed for safety. C. On 11/18/25 at 5:23 pm, during an interview with R #24's daughter, she stated R #24 is a fall risk and should have a fall mat present near the bed when R #24 is lying in bed. R #24's daughter also stated when she visits R #24, a fall mat is often not present when R #24 is lying in bed. D. On 11/24/25 at 1:54 pm, observation of R #24's room revealed R #24 laid in bed asleep without a fall mat present next to R #24's bed. E. On 11/24/25 at 2:01 pm, during an interview with Certified Nursing Assistant (CNA) #1, she confirmed R #24 did not have a fall mat present while R #24 was lying in bed. CNA #1 stated a fall mat should be present. F. On 11/25/25 at 3:02 pm, during an interview with the Director of Rehab (DOR), she stated R #24 has a history of falls and a fall mat should be present for her when in bed. G. On 11/25/25 at 4:40 pm, during an interview with the Director of Nursing (DON), she stated a fall mat should be present every time when R #24 is in bed due to her being a fall risk. R #71: H. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. I. Record review of R #71's physician orders dated 11/24/25 revealed a fall mat should be present when R #71 is in bed. J. On 11/24/25 at 1:47 pm, observation of R #71's room, revealed R #71 laid in bed without a fall mat present. K. On 11/25/25 at 2:11 pm, during an interview with the Scheduler (SCH), she confirmed a fall mat was not present while R #71 was lying in bed. The SCH stated R #71 has a physician order for a fall mat, but there was not one in his room and should have been. L. On 11/25/25 at 4:41 pm, during an interview with the DON, she stated R #71 should have a fall mat present when he is in lying in bed as ordered by a physician.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interview, the facility failed to complete the required pharmacy review of resident medications for 5 (R #s 8, 9, 10, 11, and 71) of 7 (R #s 4, 8, 9, 10, 11, 20, and 71) residents reviewed for pharmacy reviews when the facility failed to: -Assure that residents' medications were reviewed by a licensed pharmacist monthly from August 2024, through October 2025 for R #s 10, 11, and 71 -To carry out pharmacy recommendations that were approved by the provider for R #s 8, and 9 These deficient practices are likely to result in residents receiving medications that are unnecessary for their health. The findings are: A. Record review of the facility's provided Pharmacy Recommendations for the month of October 2025 revealed a licensed pharmacist did not complete a pharmacy review for R #10. B. Record review of the facility's provided Pharmacy Recommendations for the month of October 2025 revealed a licensed pharmacist did not complete a pharmacy review for R #10. C. Record review of the facility's provided Pharmacy Recommendations for the month of June 2025 revealed a licensed pharmacist did not complete a pharmacy review for R #71. D. Record review of the facility's provided Pharmacy Recommendations revealed that Medication Regime Review (MRR) documentations for R #8 for the month of September 2025 was approved by the provider but the order was not carried out. -Discontinue Oxycodone (prescription medication used to treat pain) 5 milligrams (mg) every 8 hours as needed. -Discontinue Tramadol (prescription medication used to treat pain) 50 mg every 6 hours as needed. E. Record review of the facility's Pharmacy Recommendations for the month of August 2025 revealed that MRR documentations for R #9 for the month of August 2025 was approved by the provider but the order was not carried out to monitor for dermatological side effects (such as skin rash or allergic reaction like hives) and immediately contact the prescriber to discontinue allopurinol (prescription medication used to lower high uric acid levels in the blood) at the first sign of a skin rash or allergic reaction. F. Record review of the facility ‘s provided Pharmacy Recommendations for the month of March and June 2025 revealed MRR documentations for R #10 were approved by the provider but the orders were not carried out to monitor for involuntary movements now and at least every 6 months or per facility protocol. G. On 11/25/25 at 4:25 pm, during an interview with the Director of Nursing (DON), she confirmed that MMR for R #s 10, 11 and 71 were missed and should have been addressed monthly. DON also confirmed that the approved pharmacy recommendations for R #s 8, 9, and 10 should have been carried out with new orders added to the EMR (electronic medical records) and it did not occur.