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	04/09/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report incidents involving allegations of abuse to the State Agency for 2 (R #2 and R #3) of 3 (R #2, R #3, and R #9) residents reviewed for abuse. If the facility fails to report allegations of abuse to the State Agency, then the State Agency is unable to ensure residents are free from abuse. The findings are:R #2A. Record review of the facility's Incident by Incident Type report provided by the Director of Nursing (DON) on 04/08/26 revealed an incident on 04/01/26 resulting in serious bodily injury (bruise) for R #2.B. Record Review of R #2's Change of Condition assessment dated [DATE] revealed R #2 was hit by another resident with a wallet chain. R #2 sustained red spotted bruises to left arm.C. Record review of the facility's reportable incident list provided by the Administrator (ADM) on 04/08/26 revealed no report for R #2 was submitted to the State Agency for the incident on 04/01/26.D. On 04/08/26 at 11:58 am, an interview and observation of R #2 revealed bruises on R #2's left arm. He confirmed he was in a physical altercation with another resident and was hit with a chain by the resident. R #3E. Record review of the facility's Incident by Incident Type report provided by the DON on 04/08/26 revealed an incident on 04/01/26 resulting in serious bodily injury (bruise) for R #3.F. Record review of progress note dated 04/01/26 revealed R #3 reported he was hit on the head by another resident. R #3 was noted to have a slightly reddened area on the right side of his head.G. Record review of the facility's reportable incident list provided by the ADM on 04/08/26 revealed no report for R #3 was submitted to the State Agency for the incident on 04/01/26.H. On 04/09/26 at 10:01 am during an interview with the ADM, he confirmed the reports for R #2 and R #3 were not filed.

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 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 prevent significant medication errors for 3 (R #2, R #3, and R #9) of 5 (R #2, R #3, R #4, and R #5) residents reviewed for medication errors when the facility did not administer night medications on 03/30/26. This deficient practice is likely to result in residents having adverse effects (unwanted, harmful, or abnormal result). The findings are:R #2A. Record review of R #2's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses:1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),2. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol),3. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),4. Anxiety (feelings of fear or apprehension),5. Gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining),6. Chronic obstructive pulmonary disease (COPD; lung disease),B. Record review of R #2's medication administration record (MAR) dated March 2026 revealed that on the night of 03/30/26 R #2 did not receive:1. Docusate sodium (a medication used to treat constipation),2. Fluticasone-salmeterol (an inhaled medication used to treat COPD), 3. Glipizide (a medication used to treat DM2),4. Insulin (a medication used to treat DM2),5. Nubeqa (a medication used to treat prostate cancer),6. Tolterodine tartrate ER (a medication used to treat overactive bladder). R #3C. Record review of R #3's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),2. Anxiety (feelings of fear or apprehension),3. Essential (primary) hypertension (HTN; high blood pressure).D. Record review of R #3's MAR dated March 2026 revealed that on 03/30/26 R #3 did not receive:1. Donepezil HCl (a medication used to treat dementia),2. Lorazepam (a medication used to treat anxiety),3. Trazodone HCl (a medication used to treat depression),4. Levetiracetam (a medication used to treat seizures),5. Metoprolol tartrate (a medication used to treat HTN). R #9E. Record review of R #9's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Essential hypertension,2. Insomnia (a common sleep disorder),3. Generalized edema (swelling caused by excess fluid).F. Record review of R #9's MAR dated March 2026 revealed that on the night of 03/30/26 R #3 did not receive:1. Melatonin (a medication used to treat insomnia),2. Senna (a tablet used to treat constipation),3. Eliquis (an anticoagulant medication),4. Gabapentin (a medication used to treat chronic pain),5. Lasix (a medication used to treat peripheral edema). G. Record review of the facility's Incident by Type log revealed no adverse reactions to residents that did not receive their medications on the night of 03/30/26.H. On 04/09/26 at 10:17 am, during an interview with the Administrator (ADM), he stated that there was a computer issue that stopped the facility staff that were working from accessing the MAR, so night medications were not given. The ADM stated that the facility staff that were working should have called administrative staff to report the issue and access the backup MARs but failed to do so. The ADM confirmed that no adverse reactions occurred due to this incident.