

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE  1650 Galisteo Street 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>39509</p> <p>Based on observation and interview, the facility failed to safeguard clinical record information when staff disclosed private health information (PHI) to unauthorized persons for 1 (R #1) of 1 (R #1) resident reviewed. This deficient practice likely resulted in R #1's clinical information not being sufficiently safe guarded. The findings are:</p> <p>A. Record review of R #1's face sheet, dated 09/24/24, revealed the resident was admitted to facility on 03/26/24 with multiple diagnoses to include dementia (a chronic, progressive condition of the brain that causes mental and memory decline) and Parkinson's disease (a chronic progressive condition of the nervous system that causes tremors). Further review revealed R #1's contact persons included his daughter, son, and other (niece).</p> <p>B. Record review of R #1 daily care note, dated 09/15/24, revealed R #1 experienced a decline in health that resulted in his death.</p> <p>C. On 09/20/24 at 4:21 pm during phone interview with R #1's daughter-in-law (DIL), she stated she was a former employee of the facility. She stated she was familiar with many staff who currently worked in the facility. The DIL stated she received a text message from a friend/former employee of the facility on 09/18/24. She stated the former employee reported to her in the text that she (former employee) received information from Licensed Practical Nurse (LPN) #1 that prior to R #1's death, he was found in his room with feces smeared on his body, face, and hands. She stated the text suggested there was possible abuse by Certified Nurses Aide (CNA) #1 towards R #1 on 09/14/24, and it also included the condition of R #1 prior to and at the time of his passing on 09/14/24. The DIL stated the text message included a statement that conjectured (an opinion about something on the basis of incomplete information) the cause of R #1's death was related to choking on feces. The DIL stated she contacted the Social Services Director (SSD) who confirmed the information that was received in the text message about R #1 and CNA #1. The DIL stated the SSD said it was true and assured her that CNA #1 was suspended.</p> <p>E. On 09/20/24 at 2:37 pm during an interview with the facility Administrator, he stated he heard R #1's family member/former employee was under the impression R #1 was neglected while at the facility. He stated the family member felt there was a connection between R #1 being neglected and the resident passing away later that evening. The Administrator further stated he had no idea how or who contacted R #1's DIL. Administrator stated resident health care information should only be shared with the people listed as the resident's contacts.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE  1650 Galisteo Street 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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>F. On 09/20/24 at 3:28 pm during an interview with the SSD, she stated she spoke with R #1's DIL. The SSD stated she did not give the DIL any information about what transpired the night R #1 passed away. She stated she was aware of the incident, because it was brought up in a staff meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE  1650 Galisteo Street 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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39509</p> <p>Based on record review and interview, the facility failed to protect 1 (R #1) of 3 (R #1-3) residents reviewed from abuse and neglect when a staff member used loud, foul, abusive language and then abandoned R #1 instead of providing care by leaving the unit. This deficient practice is likely resulted in R #1 being left covered in feces. The findings are:</p> <p>A. Record review of R #1's face sheet, dated 09/24/24, revealed the resident was admitted to the facility on [DATE] with multiple diagnoses including:</p> <ul style="list-style-type: none"> <li>- Dementia (loss of cognitive functioning),</li> <li>- Altered mental status (a change in how well the brain functions),</li> <li>- Hallucinations (false perceptions, where you sense an object, person, or event even though it is not really there or did not happen).</li> </ul> <p>B. Record review of R #1's daily care note, dated 09/15/24, revealed Licensed Practical Nurse (LPN) #1 and LPN #2 heard CNA #1 verbally yelling and cursing at 9:30 pm. LPN #1 went to investigate and found R #1 in his room, alone, and covered in feces. Nursing assessment completed and management was notified. Certified Nurses Aide (CNA) # 2 and LPN #1 cleaned up R #1. Staff were unable to locate CNA #1, who was originally heard verbally yelling and cursing.</p> <p>C. On 09/20/24 at 12:40 pm during phone interview with LPN #1, she stated she and CNA #1 were assigned to provide care to residents on the memory care unit during the night shift on 09/14/24. LPN #1 stated R #1 was a resident of the memory care unit. She stated R #1 was generally very kind and pleasant, but he was very confused. LPN #1 stated R #1 sat on his chair for approximately an hour and wanted to go to bed. She stated she had asked CNA #1 to get R #1 changed and put him to bed. LPN #1 stated she administered medications on the evening of 09/14/24 and she heard CNA #1 in R #1's room yelling profanities and stating he quit. She stated she went to R #1's room, and CNA #1 was no longer in the resident's room. She stated R #1 sat in a chair and wore only a t-shirt. She stated R #1 was covered in feces (his face, his hands, his mouth, his legs and all over his body) and some of the feces was already dried. LPN #1 stated R #1 had feces on his hand which he had in his mouth. She stated feces was also all over the resident's bed, floor, and walls. LPN #1 stated she was unable to locate CNA #1 on the memory care unit. LPN #1 stated she called CNA #2 from another unit to come to the memory unit to assist R #1 with a shower and clean up the feces on the chair and bed. LPN #1 stated CNA #1 returned to the unit later, continued to yell profanities, and left again. LPN #1 stated CNA #1 was upset, because R #1 got feces on his clothing while he tried to move R #1 onto the bed. She stated CNA #1 reported loose feces spread all over the room when he removed the resident's brief. LPN #1 stated she felt CNA #1's behavior was threatening. She stated CNA #1 was full of anger and rage and acting erratic, and she felt the safety of the other residents was at risk. LPN #1 stated CNA #1 returned again to the unit and was asked to leave. LPN #1 stated CNA #1 was only in the room with R #1 for approximately 5 to 10 minutes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE  1650 Galisteo Street 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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 09/20/24 at 1:35 pm during phone interview with LPN #2, she stated she was assigned to the memory care unit on 09/14/24. LPN #2 stated she heard CNA #1 yell profanities in the hallway of the unit. LPN #2 stated she saw CNA #1 walk down the hallway yelling, with a brief in his hands. She stated the brief had so much feces on it, that the feces dripped on the floor. LPN #2 stated she walked into R #1's room, and R #1 had feces on his face, his shirt, and on his body. LPN #2 stated CNA #1 left the unit and was gone for some time. She stated CNA #1 returned later, continued to yell profanities, and then left the unit again. LPN #2 stated she did not see CNA #1 after that.</p> <p>E. On 09/20/24 at 2:37 pm during interview with Administrator (ADM), he stated he was contacted by telephone between 9:00 pm and 10:00 pm on 09/14/24 and was informed CNA #1 used loud profane language while working on the memory care unit. The ADM stated he was able to speak with CNA #1 and confirmed CNA #1 used loud profane language in front of R #1 and in the hallway of the memory unit. The ADM stated CNA #1 left the building and left R #1 to sit in his room while covered in feces. The ADM stated he submitted a report of the incident to the State Agency, and he was investigating the incident.</p> <p>F. Several attempts were made to contact CNA #1 with no results.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE  1650 Galisteo Street 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>39509</p> <p>Based on observation, record review, and interview, the facility failed to ensure an allegation of staff-to-resident abuse was reported within two hours to the State Agency for 1 (R #1) of 1 (R #1) resident reviewed. If the facility is not immediately reporting allegations of abuse and conducting an investigation, residents are likely to be at risk of further abuse. The findings are:</p> <p>A. Record review of R #1's face sheet, dated 09/24/24, revealed the resident was admitted to facility on 03/26/24 with multiple diagnoses to include dementia (a chronic, progressive condition of the brain that causes mental and memory decline) and Parkinsonism (a chronic progressive condition of the nervous system that causes tremors).</p> <p>B. On 09/20/24 at 2:37 pm during interview and record review with the Administrator (ADM), he stated he was contacted by telephone between 9:00 pm and 10:00 pm on 09/14/24 and was informed CNA #1 used loud profane language while working with R #1 on the memory care unit. He stated staff heard CNA #1 yelling and cussing loudly at R #1 and then CNA #1 left the area and clocked out. The ADM stated CNA #1 returned later and admitted he became angry, was frustrated, and cursed loudly at R #1 on 09/14/24. The ADM stated he told CNA #1 to leave the building. The ADM provided a copy of an initial incident report which briefly described the incident as abuse and was submitted to the State Agency on 09/15/24 at 10:34 am. The ADM stated the facility submitted the report later than the 2 hours required.</p> <p>C. Record review of the State Agency records revealed a report dated 09/15/24 and received at 10:34 am from the facility.</p>		