STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325038	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Real	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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to ensure staff allowed a resident to remain in the facility or staff documented the reason for the resident's discharge, the location of the discharge/transfer, the evidence of the facility's efforts to meet the resident's needs prior to discharge, and the instructions for continued care for 1 (R #1) of 1 (R #1) resident reviewed for facility discharges. This deficient practice likely resulted in an unsafe, unplanned discharge in which the facility transferred R #1 to a local shelter without medications and care instructions. The findings are: A. Record review of R #1's face sheet, dated 10/16/24, revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: - Epilepsy (a chronic condition of the brain that causes seizures), - Dysphagia (difficulty swallowing), - Non-st elevated myocardial infarction (heart attack), - Pain. There was no POA or Emergency Contact listed. B. Record review of R #1's Medication Administration Record, dated September 2024, revealed staff administered the following medications to R #1: - Amlodipine (lowers blood pressure by relaxing the blood vessels so the heart does not pump as hard) 5 milligrams (mg) daily for hypertension, - Aspirin EC 81 mg daily for coronary artery disease, - Citalopram (increases the amount of serotonin in the brain and helps maintain mental balance) 10 mg daily for depression, - Depakene (anticonvulsant) 250 mg three times daily for seizure disorder, (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: 325038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Galisteo Street Santa Fe, NM 87505	

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ducosate (stool softener) 100 mg daily for constipation, - Duloxetine (antidepressant and nerve pain medication) 60 mg daily for isolation, aggression, - Gabapentin (nerve pain medication and anticonvulsant) 300 mg four times daily for chronic pain, - Hydrocodone-acetaminophen 10-325 three times daily for chronic pain, - Ipratropium-Albuterol inhaler as needed for shortness of breath, - Levetiracetam (anticonvulsant) 750 mg daily for seizure disorder, - Melatonin 3 mg nightly for insomnia, - Mirtazapine (antidepressant) 30 mg nightly for decreased appetite, isolation, - Zostrix Cream (topical pain ointment) apply to hip three times daily for chronic pain, - This list is not all inclusive. C. Record review of R #1's annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/16/24, revealed staff documented the following: - Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) revealed a score of 14 out of 15, cognitively intact. - R #1 did not have any behaviors to include physical or verbal behaviors towards others, - R #1 was independent in the areas of eating, toileting, bathing, dressing, and personal hygiene. D. Record review of R #1's care plan revealed the following: - A discharge plan, initiated 07/07/22, R #1 had the potential to be discharged with the expectation his admission was for skilled (advanced nursing care) short term (unknown term) stay. - Interventions: Discuss and document resident's concern and desires regarding discharge, - Discharge plan, updated 04/12/23, R #1 was expected to discharge to community re-integration program (a specific program was not identified) that did not include an apartment. - Interventions: Consider planning needs, take into consideration plans for resident goals, cognitive skills, functional mobility and needs for assistive devices; inform the interdisciplinary team (IDT) members and physician/mid-level practitioner of the resident's desire to be discharged . Make referrals to community-based agencies, providers, and services to communicate the resident's needs and barriers to care. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 10/16/24 at 10:30 am during a phone interview with the New Mexico Council on Aging Case Manager and Housing Specialist (CMHM), she stated she worked with R #1 to assist in his request to transfer to an independent living situation. She stated she was notified on 09/12/24 that the facility discharged R #1 from the facility and took him to a local homeless shelter. The CMHM stated she was informed the facility staff dropped R #1 off at the front door of the shelter, and he stayed there for 14 nights. The CMHM stated after the 14 days, R #1 was taken by ambulance from the shelter to the hospital where he was admitted and treated for pneumonia. The CMHM stated R #1 was discharged from the hospital, and there was not any record of where he went. The CMHM stated she did not know where the resident was anymore, and he was removed from her caseload. F. On 10/16/24 at 1:50 pm during a phone interview with the Homeless Shelter Case Manager (HSCM), she stated R #1 arrived at the shelter on the evening of 09/11/24 with a suitcase of clothing. She stated R #1 did not have any medications, documentation, or medical records. She stated R #1 was basically dumped at her facility. The HSCM stated she did not receive any advance notice R #1 was coming to the shelter. The HSCM stated R #1 resided at the shelter for the next 14 days. The HSCM stated R #1 began to have medical problems, difficulty breathing, and shortness of breath on 09/25/24, and R #1 called 911 for emergency services. The HSCM stated an ambulance arrived, and R #1 left the shelter. The HSCM stated the services offered at the shelter included coming each evening to the shelter for a bed, an evening meal, and a morning meal. The HSCM stated the expectation was for individuals to exit the building each day and return that evening to be readmitted . She stated the intention of the shelter service is to provide only a short-term reprieve from being on the streets. She stated the shelter was not meant to be a permanent home for anyone. G. Record review of R #1's medical record revealed the following: - Facesheet: R #1 was discharged from the facility on 09/11/24 to private home/apartment without home health services. - Physician orders did not contain any documentation regarding discharge or transfer orders, dated on or about 09/11/24. - Nursing daily care notes, dated 05/09/24 through 09/16/24, revealed the notes did not contain any documentation R #1 was discharged from the facility, considered for discharged from the facility, or any discharge plans. Further review revealed staff did not document that R #1 requested to be discharged from the facility, transferred to another facility, or placed at a local shelter. The daily notes also did not document that staff gave R #1 any advance notice or assistance with his discharge on 09/11/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 10/16/24 at 2:35 pm and 10/17/24 at 11:30 am during interview with facility Administrator (ADM), he stated R #1 was discharged at his own request. The ADM described the discharge as safe. He stated R #1 had a series of inappropriate behaviors and acted out on 09/11/24. The ADM stated he spoke with the Director of Social Services who recommended the resident be taken to the local homeless shelter. The ADM stated when he entered R #1's room to talk to the resident about his behaviors, he found a baggie with some pills and what was suspected to be marijuana. The ADM stated he told R #1 having the medication and suspected marijuana in his room was inappropriate. He stated he told R #1 that he could leave facility and go to the homeless shelter. The ADM stated R #1 was agreeable to the discharge to the homeless facility. The ADM stated he and a nurse helped R #1 pack some of his personal items into a suitcase to take with him to the shelter. The ADM stated he immediately drove R #1 to the shelter in his personal car and dropped the resident off at the front door. The ADM stated he did not provide any documentation of R #1's history, needs, and medical orders to the resident or the shelter. The ADM stated R #1's medications were packed by the nurse and sent with him. The ADM stated staff did not contact the resident's doctor regarding the discharge. I. On 10/17/24 at 11:40 am during interview with the HSCM and the facility's Ombudsman, they stated they were in touch with R #1 prior to his discharge on 09/11/24. They stated they felt staff should have attempted other plans that were available before staff drove R #1 to a shelter. They stated R #1's discharge was untimely, unplanned, and inappropriate. J. On 10/17/24 at 2:00 pm during interview with the ADM, he stated he reviewed R #1's medical record, and there was not any documentation to show R #1 acted out, had a current or past behavior contract (an agreement between resident and facility to not misbehave and to comply with the facility rules), had psychiatric evaluation or counseling services, had a physician review and order for discharge, or had any discharge planning to include a referral for services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to ensure staff provided a written notice to a resident which included the reasons for the discharge and to send a copy of that notice to the Ombudsman (an advocate for the residents) for 1 (R #1) of 1 (R #1) resident sampled for discharges or transfers. Without approporiate notice, the resident likely was not able to adequately advocate for his rights and to ensure that he was not inappropriately transfered or discharged . The findings are: A. Record review of R #1's face sheet, dated 10/16/24, revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: - Epilepsy (a chronic condition of the brain that causes seizures), - Dysphagia (difficulty swallowing), - Non-st elevated myocardial infarction (heart attack), - Pain. B. Record review of R #1's annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/16/24, revealed staff documented the following: - Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) revealed a score of 14 out of 15, cognitively intact. - R #1 did not have any behaviors to include physical or verbal behaviors towards others, - R #1 was independent in the areas of eating, toileting, bathing, dressing, and personal hygiene. C. Record review of R #1's physician orders revealed the orders did not contain an order for R #1 to be discharged or transferred from the facility on 09/11/24. D. Nursing daily care notes, dated 05/09/24 through 09/16/24, revealed the notes did not contain any documentation R #1 was discharged from the facility, considered for discharged from the facility, or any discharge plans. Further review revealed staff did not document any notification to the Ombudsman of R #1's discharge on or before 09/11/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 10/16/24 at 10:30 am during a phone interview with the New Mexico Council on Aging Case Manager and Housing Specialist (CMHM), she stated she worked with R #1 to assist in his request to transfer to an independent living situation. She stated she was notified on 09/12/24 that the facility discharged R #1 from the facility and took him to a local homeless shelter. The CMHM stated she was informed that the facility staff dropped R #1 off at the front door of the shelter, and he stayed there for 14 nights. The CMHM stated after the 14 days, R #1 was taken by ambulance from the shelter to the hospital where he was admitted and treated for pneumonia. The CMHM stated R #1 was discharged from the hospital, and there was not any record of where he went. The CMHM stated she did not know where he was anymore and he had been removed from her caseload. F. On 10/17/24 at 11:40 am during interview with the Ombudsman, she stated she did not receive a notice of discharge for R #1, and the facility did not inform her of R #1's discharged anytime prior to 09/11/24 or since. The Ombudsman stated R #1's discharge was untimely, unplanned, and inappropriate. G. On 10/17/24 at 2:00 pm during interview with the Administrator (ADM), he stated he did not provide any notice of discharge to R #1 or the Ombudsman prior to R #1's discharge. ADM reviewed R #1's medical records, and confirmed the records did not contain any documentation of a written discharge notice, documentation regarding R #1's discharge, the reason for the discharge, or the actions taken at the time of his discharge.

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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 0684 Level of Harm - Minimal harm or potential for 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** 47091 Based on record review and interview, the Certified Nurse Aide (CNA) #1 failed to report a resident's fall with injury to the facility nurse for 1 (R #2) of 1 (R #2) residents reviewed for falls. Failure to report a fall immediately to the nurse to conduct an assessment could likely result in the resident not receiving the necessary care needed for injuries sustained or for prolonged pain and discomfort. The findings are: A. Record review of R #2's Care Plan, dated 09/16/24, revealed R #2 was admitted to the facility on [DATE] and the following: - Diagnoses: - Muscle weakness, - Dysphasia (trouble swallowing), - Right sided hemiplegia following cerebral infarction (paralysis of right side following a stroke), - Hypotension (low blood pressure), - Unspecified dementia (a group of symptoms affecting memory). - R #2 was at risk for falls due to impaired mobility (lack of strength to walk, grasp or lift objects), poor safety awareness (impaired ability to judge safety), and psychosis with behaviors (changes in a person's thoughts, feelings, and actions that indicate a loss of contact with reality). B. Record review of R #2's progress notes, dated 09/21/24, revealed Nurse #1 witnessed Certified Nurse Aide (CNA) #1 propelling R #2 towards the dining room in her wheelchair on 09/21/24 at 5:45 am. Nurse #1 immediately noticed the presence of bright red blood coming from the right upper forearm/elbow area and a couple of finger-sized skin tears. R #2 had a softball sized swollen contusion (bruise) to her right upper forehead/temple area. C. Record review of the facility's Complaint Narrative Investigation Report (five day report to state agency), undated , revealed the following: - On 09/21/24 at 4:30 am, CNA #1 found R #2 with her lower body, including her legs, on the floor; and her upper body, including her arms, chest, and head, on her bed. - CNA #1 attempted to place R #2's lower body into the resident's bed on his own. - CNA #2 witnessed the incident and stated they observed CNA #1 struggling to return R #2 back into the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The report further revealed that after further questioning by Nurse #1, CNA #1 stated that he failed to report the fall to Nurse #1. CNA #1 further failed to report to Nurse #1 that he noticed R #2 had sustained injuries to the right side of her head and her right elbow. D. On 10/16/24 at 1:50 pm during interview with facility's administrator (ADM), he stated CNA #1 was terminated during the investigation of R #2's fall on 09/21/24 for failure to report the fall to the nurse on duty. He stated CNA #1 admitted he did not report the resident's fall even though he was trained to do so. The ADM stated the expectation was for all incidents/accidents to be reported to the nurse and for staff to complete an incident report. E. On 10/16/24 at 3:33 pm during interview with Nurse #1, he stated CNA #1 confirmed he found R #2 partially out of bed on 09/21/24 at 4:30 am. Nurse #1 stated CNA #1 reported he did not report the incident to Nurse #1 and he returned R #2 back to bed Nurse #1 stated he assessed the resident, dressed the wounds, and sent R #2 out by ambulance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47091 Based on record review and interview, the facility failed to ensure 1 (R #3) of 1 (R #3) resident was free from accidents when staff failed to provide adequate supervision while the resident used the toilet. If the care plan is not followed according to the resident's needs then the resident is not likely to get the proper assistance needed which places the resident at an increased risk for injury. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted to the facility on [DATE] with the following diagnoses: - Non-traumatic interceder hemorrhage, unspecified (bleeding in the brain), - Cerebral edema (swelling in the brain), - Cognitive communication deficit (difficulty communicating), - Other lack of coordination (can affect balance, speech, and fine motor skills), - Muscle weakness (generalized: lack of strength in one or more muscles), - Difficulty in walking, not elsewhere classified, - Need for assistance with personal care. B. Record review of R #3's care plan, dated 03/15/24, revealed the following: - R #3 was at risk for falls related to weakness, impaired mobility, and pain. - Staff to offer toileting (assist resident to the bathroom) every two hours when resident was awake. - Staff directed not to leave the resident alone in the bathroom. Please supervise. - R #3 required assistance/was dependent for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care. C. Record review of R #3's progress note, dated 04/17/24, revealed the resident was found on floor, in bathroom in front of the toilet. The resident stated he was attempting to reach the string to call for help. The resident had an abrasion (scrape or superficial skin wound) to mid-right back and abrasion to left elbow. R #3 did not recall how long he was left alone, but he stated it was for a long time. The resident reported he called for help and tried to get off the toilet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. On 10/17/24 at 2:37 pm during interview with the Director of Nursing (DON), he stated it is his expectation staff did not leave R #3 alone in the bathroom. The DON was unsure how long staff left the resident alone in the restroom. The DON stated the resident have tried to get up when the fall happened.