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	03/27/2025

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 0580 Level of Harm - Minimal harm or potential for 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. 41988 Based on interviews, the facility failed to notify the facility providers (Nurse Practitioner, Physician) and the resident's Power of Attorney (POA- medical decision maker), when a resident experienced a new coccyx (tail bone) pressure ulcer (localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of usually long-term pressure, or pressure in combination with shear or friction) for 1 (R #3) of 1 (R #3) resident reviewed for a change of condition. This deficient practice is likely to result in a delay in treatment or inadequate treatment. The findings are: A. Refer to F0686 for pertinent findings related to this citation. B. On 03/25/25 at 10:59 am during an interview with R #3's POA, he stated he was not notified of R #3 having a new pressure ulcer located on his coccyx (discovered on 07/03/24) by the facility. R #3's POA confirmed he was made aware of the new pressure ulcer by the hospital on 08/05/24. C. On 03/26/25 at 5:08 pm during an interview with the Skin Health Lead (SHL), she stated she could not remember if she contacted R #3's POA after discovering R #3's new coccyx pressure ulcer. The SHL also she did not remember contacting a provider for R #3's coccyx pressure ulcer. The SHL confirmed a provider and R #3's POA should have been notified of R #3's new coccyx pressure ulcer. D. On 03/26/25 at 5:39 pm during an interview with the Unit Manager (UM) #1, she stated if a resident develops a new wound or pressure ulcer, a provider and the resident's POA should be notified immediately. E. On 03/27/25 at 2:05 pm during an interview with the Nurse Practitioner (NP) #1, she stated she was not notified of R #3's coccyx pressure and she did not know that R #3 had a pressure ulcer on his coccyx. The NP #1 confirmed she would expect to be notified immediately of a new pressure ulcer that developed on one of her residents. F. On 03/27/25 at 2:38 pm during an interview with the Director of Nursing (DON), she stated a provider should have been notified of R #3's coccyx pressure ulcer as soon as the pressure ulcer was identified, and one was not. The DON also confirmed R #3's POA should have been notified as well.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services to prevent the development and worsening of pressure wounds (also called a pressure injury or pressure ulcer; skin damage which results from unrelieved pressure on the body) for 1 (R #3) of 1 (R #3) resident reviewed when staff failed to: 1. Identify R #3's new coccyx (tailbone) pressure wound with measurements of the new pressure wound, while monitoring for changes in the pressure wound. 2. Complete and document weekly skin evaluations that included R #3's new coccyx pressure wound. These deficient practices are likely to lead to residents developing pressure ulcers and wounds worsening. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] and discharged to the hospital on 08/05/24. B. Record review of R #3's hospital discharge documentation dated 06/20/24 revealed R #3 was sent to the hospital on 06/07/24 for altered mental status and R #3 had an unstaged and unmeasured pressure wound on the sacral region (base of the spine but above coccyx region) when he was discharged on [DATE]. C. Record review of R #3's wound care supply order (wound care supply vendor) dated 06/28/24 revealed R #3 required additional wound care supplies for a pressure ulcer on R #3's left foot/heel. No other bodily areas where mentioned for R #3, indicating R #3 did not have a coccyx pressure wound or the coccyx pressure wound was not identified by the facility at this time. D. Record review of R #3's skin only evaluation revealed the following: - 07/03/24: R #3 had a newly acquired pressure ulcer located on R #3's coccyx, listed as a stage two (partial-thickness skin loss with exposed dermis). Measurements were not documented for R #3's newly acquired coccyx pressure ulcer. R #3's left heel/foot pressure ulcer was documented. - 07/23/24: only R #3's left foot/heel pressure ulcer was documented. R #3's coccyx pressure ulcer was not documented, and measurements were still not documented for R #3's coccyx pressure ulcer. E. Record review of R #3's physician orders dated 07/03/24 revealed nursing staff were to apply barrier cream to R #3's buttocks, every day and night shift for stage two pressure ulcer to coccyx. F. Record review of R #3's skin and wound evaluation (completed by Skin Health Lead-SHL) revealed the following: - 06/26/24, only R #3's left calf abrasion (scrape) was documented. R #3's coccyx pressure ulcer and left foot/heel pressure was not documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 07/09/24, only R #3's left foot/heel pressure ulcer was documented. R #3's coccyx pressure ulcer was not documented. - 07/18/24, only R #3's left foot/heel pressure ulcer was documented. R #3's coccyx pressure ulcer was not documented. - 07/25/24, only R #3's left foot/heel pressure ulcer was documented. R #3's coccyx pressure ulcer was not documented. - 07/30/24, only R #3's left foot/heel pressure ulcer was documented. R #3's coccyx pressure ulcer was not documented. G. Record review of R #3's Medication Administration Record (MAR) dated 07/03/24 through 07/31/24 revealed the nursing staff applied barrier cream to R #3's coccyx pressure ulcer 58 times out of 62 opportunities. This indicated the nursing staff was aware of R #3's coccyx pressure ulcer, but the nursing staff did not document that R #3 had a coccyx pressure ulcer, and no measurements were ever taken of R #3's coccyx pressure ulcer to monitor for changes by facility nursing staff. H. Record review of R #3's shower sheets dated 07/11/24 through 07/31/24 revealed the following: - 07/11/24: R #3 had redness to his coccyx area. - 07/18/24: R #3 had redness to his coccyx area. - 07/25/24: R #3 had redness to his coccyx area. These shower sheets indicated the facility Certified Nursing Assistants (CNAs) were aware of R #3's coccyx pressure ulcer and documented skin damage to the area, but facility nurses did not measure or document R #3's coccyx pressure ulcer. I. Record review of R #3's hospital documentation dated 08/05/24 revealed R #3 had a large (unmeasured by hospital staff) stage two pressure ulcer located on his coccyx. J. Record review of R #3's nursing progress notes dated 08/28/24 revealed, the facility Administrator (ADM) spoke to R #3's brother about a large wound to R #3's bottom (coccyx) that was found in the hospital without any prior documentation. The ADM reviewed the shower sheets and determined that R #3 did not have a pressure ulcer located on his bottom (coccyx) prior to going to the hospital on 08/05/24. K. On 03/25/25 at 10:59 am during an interview with R #3's brother, he stated that when R #3 went to the hospital on 08/05/24, he was contacted by the hospital staff informing him of a large pressure ulcer on R #3's coccyx. R #3's brother then contacted the facility ADM, who told him that R #3 did not have a pressure ulcer located on his coccyx. R #3's brother stated that R #3 was in a lot of pain at the hospital because of this pressure ulcer, and R #3 would cry out in pain. R #3's brother also stated he was not informed of R #3's coccyx pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L. On 03/26/25 at 3:14 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated she remembered R #3 having a stage two pressure ulcer on his coccyx prior to him discharging because she remembered applying barrier cream to R #3's coccyx pressure ulcer. LPN #2 also stated that other facility nurses were treating R #3's coccyx pressure ulcer with barrier cream. M. On 03/26/25 at 5:07 pm during an interview with the SHL, she stated she believed R #3 returned from the hospital on June 20 (2024) with the stage two pressure ulcer located on his coccyx. The SHL stated that a picture of R #3's coccyx pressure ulcer, along with measurements, should have been completed and documented, but were not. The SHL confirmed other nurses should have documented R #3's coccyx pressure ulcer more than just the one time the pressure ulcer was documented on 07/03/24, and they did not. The SHL stated R #3's coccyx pressure ulcer treatment and documentation was not up to her expectations, and R #3's coccyx pressure ulcer should have been measured and monitored for changes, but was not. N. On 03/26/25 at 5:36 pm during an interview with Unit Manager (UM) #1, she stated the facility nurses are expected to complete weekly pressure ulcers skin checks with measurements for all residents, and include every pressure ulcer or skin issue in the documentation. O. On 03/27/25 at 2:03 pm during an interview with the Nurse Practitioner (NP) #1, she stated that all residents who have a pressure ulcer should be accurately documented with measurements to track for any changes. P. On 03/27/25 at 2:33 pm during an interview with the Director of Nursing (DON), she stated the admitting nurse for R #3 in June (2024- after returning from the hospital) did not document R #3's coccyx pressure ulcer and should have. The DON also stated the SHL should have measured R #3's coccyx pressure ulcer and track the pressure ulcer, but the SHL did not. The DON confirmed R #3's coccyx pressure ulcer management and documentation was not completed and accurate as expected, and should have been.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47031 Based on a record review and interview, the facility failed to ensure shower sheets records were complete for 1 (R #1) of 1 (R #1) resident reviewed for complete and accurate shower documentation. This deficient practice is likely to result in staff not having the information they need to provide competent, comprehensive care and services to residents. The findings are: A. Record Review of R #1's face sheet revealed R #1 was admitted to the facility on [DATE]. B. Record review of the facility's shower schedule revealed R #1 was to be offered/given a bath/shower every Monday, Wednesday, and Friday and was not documented that R#1 refused showers on some of those days. C. Record review of R #1's documentation survey report (ADL tracking form on the electronic health record [EHR]) revealed the following: - January 2025, R #1 had seven baths/showers documented out of 21 opportunities and did not have any refusals documented, - February 2025, R #1 had five baths/showers documented out of 23 opportunities with five refusals documented. - March 2025, R #1 had nine baths/showers documented out of 31 opportunities with two refusals documented. D. On 03/26/25 at 12:29 pm, during an interview with Certified Nursing Assistant (CNA) #1, she confirmed showers should be documented, and they were not documented and they should be documented on the residents shower sheet. E. On 03/26/25 at 2:26 pm, during an interview with Registered Nurse (RN) #1, she confirmed she should be aware of showers that are not documented and shower sheets should be completed. F. On 03//27/25 at 1:32 pm, during an interview, the Director of Nursing (DON) confirmed there was no shower documentation of R#1 refusing showers in R #1's EMR (shower sheet) available for review and the shower documentation should be completed and documented at all times.