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	01/06/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview, the facility failed to provide written notice of discharge to the resident's representative for 1(R #12) of 3(R #1, 5 and 12) residents reviewed for discharged . If the facility is not providing written notice of discharge of a resident, then residents and their representatives will not have the contact information to appeal the decision without having to ask. The findings are: A. Record review of R #12's face sheet, dated 09/26/25, revealed R #12 was admitted to the facility on [DATE] with the following diagnoses:Dementia (a chronic progressive disease that affects memory) with other behavioral disturbance.Paroxysmal atrial fibrillation (a type of irregular heart rhythm).Restlessness and agitation.Chronic kidney disease (failure of the kidneys to properly function). History of pulmonary embolism (blood clot in the lungs).Encounter for palliative care (medical care that focuses on care and relief from serious illnesses).B. Record review of R #12's daily care notes date 06/22/25 at 3:15 pm, a change in condition for other reasons. R #12 was found in his room. R #12 was on top of the resident [R #72] with pants down and private area exposed. R #12 tried to pull down the female resident's pants and grabbed at the female resident's private parts. Primary provider notified and responded to follow facility protocol and call back with any changes. Another note at 3:16 pm regarding the incident revealed R #12 was separated from the female resident and placed on 1:1 with staff.C. Record review of R #12's medical record dated 06/22/25 revealed Notice of Intent to Discharge stated R #12 and his spouse were notified the effective Date of Discharge was 30 days from 06/22/25. Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No Date Given). Any person of the resident's choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and handwritten instructions verbal and hand deliver. The letter provided contact information (address, phone and email for (2) agencies to appeal the decision to discharge.D. Record review of R #12's daily care notes dated 06/30/25 at 2:31 pm revealed Male resident has been in line of site of nursing staff until 1230 (pm)when he went to his room and closed his door. Staff was assisting another resident at the time in a room across the hallway. Female resident [R #72] in dining room until 1245 (pm) with CNA and went wandering down the hall. Staff busy helping residents in dining room. [Name of Registered Nurse (RN) from Hospice agency] arrived at the facility to see patient at 1245. [name of Hospice RN] states she found resident in bed B lying down with another female resident [R #12] kissing and trying to put his hands down the female residents' pants. Resident has his pants partially down.E. Record review of R #12's medical record dated 06/30/25 revealed Notice of Intent to Discharge addressed to R #12 and his spouse identifies 30-day notice from date (left blank). Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No date given). Any person of the resident's (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:	(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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and a handwritten note verbal- lives 2 hrs (hours) away. Wife does not drive/also hand delivered. The letter provided contact information for (3) agencies to appeal the decision to discharge.F. On 12/18/25 at 9:09 am during interview with R #12's wife, she stated They [facility] never said anything about him being discharged . They called me late in the afternoon (on 06/30/25) to come pick him up. I said there was no way to pick him up. They said they would bring him and send him home. R #12's wife stated They said they couldn't have him any longer. I went to see him every week, sometimes twice a week. They called and said he tried to molest some gal. They got her out of the room. They called a week later. I guess she [other resident] walked and the door was open and he tried to molest her. I told her [Social Services Director] 'I don't believe you.' He could hardly walk. He had a wheelchair. I had to help him with everything. I told the gal [SSD] that called, 'He could hardly move so how could he make a pass at some gal. I don't believe you.' This gal would walk the hallway all the time and go into people's rooms. I asked 'where were you [referring to staff when resident wandered into husband's room]?' R #12's wife confirmed that she was called about the discharge but was not provided a written discharge notice. She stated that it wasn't safe to send R #12 home without more notice. She stated He was happy to be home but I was leery because I didn't know if I could take care of him. I was happy with him being there [facility] and I would have preferred if he had stayed there [facility]. I didn't know I could do anything [to contest the discharge].G. On 01/06/25 at 3:25 pm during interview with the SSD, she stated The first notice was given to wife after the first incident. When I talked to his wife, she was very tearful. She said he [R #12] has never acted like that before and had never displayed sexual behaviors. She was baffled by it. The second incident he was caught with the same resident that he was still on one to one [one staff monitoring]. He could still wheelchair himself around and this incident occurred again. That's when the Administrator said to contact his wife [for an immediate discharge]. She [Administrator] felt he was putting other residents at risk. We [with R #12's wife] did talk about a [discharge] plan because she was in her 80s and needed help transferring. The plan was to discharge him with hospice and with his medications. She said she wasn't prepared to bring him home and would need services. Hospice was to meet him there [at the home after he was transported]. SSD confirmed that she sent both written notices [from 06/22/25 and 06/30/25] with the driver to give to R #12's wife [on 06/30/25 when he was dropped off].