

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 03/26/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, record review and interview, the facility failed to ensure that 1 (R #1) of 1 (R #1) resident reviewed for catheter care had a privacy cover on their drainage bag while seated in the dining room during the breakfast food service. This deficient is likely to result in the resident's medical device being visible to other residents and staff, thereby failing to maintain the resident's dignity. The findings are: A. On 03/24/26 at 9:09 am, during an observation of the locked unit dining room, R #11 was sitting in his wheelchair. Further observation revealed R #11's drainage bag was exposed under his wheelchair with no dignity cover. B. Record review of R #11's physician's order revealed an indwelling catheter (tube inserted into the bladder to continuously drain urine, held in place by a retention balloon) was ordered on 02/01/26. C. On 03/24/26 at 9:11 am, during an interview with Registered Nurse (RN) #3, she confirmed R #11's drainage bag is exposed with no dignity cover on. RN #3 stated all drainage should be covered with a dignity cover and it did not have a cover.</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, and interviews, the facility failed to honor resident's shower preferences for 2 (R #9, and R #13) of 2 (R #9, R #13, and R #15) reviewed for showers. If the facility fails to honor resident preferences, then the residents are likely to feel as if they are not heard and that the facility does not care about their choices. The findings are:R #9:A. Record review of R #9's bathing schedule stated that he should receive 3 showers per week (Tuesday, Thursday, and Saturday)B. On [DATE] at 11:08 am during an interview with R #9, he stated They finally got the water working. They wanted us to take a shower in cold water and I refused. They only offered the sponge baths once or twice during the time the hot water was not working. If they would have offered them (sponge bath, shower) I would have taken them. I like to be clean, and I don't feel like myself if I am dirty. R #15C. Record review of R #15 Bathing schedule stated that R #15 was to receive two showers per week: Tuesday and Thursday. D. On [DATE] at 10:45 am during an interview. R #15 stated that the shower situation had been remedied for a couple of weeks, R #15 further stated that she did receive cold showers and started to refuse showers because of how cold the water was. The water used to run cold, and you didn't know whether or not you would get a shower. There was a time when the water was nice and warm then it got cold while I still had soap, so they had to rinse it off with cold water and it was horrible.E. Record review of Social Services Director (SSD)'s note dated [DATE] revealed, met to discuss concerns for R #15, R #15's daughter had concerns. R #15's daughter stated [name of R #15] had been declining showers and bed baths that were offered because the water was too cold. F. On [DATE] at 3:00 pm during an interview with Certified Nurse Assistant (CNA) #1, she stated that the water was ice cold. My coworker (CNA #3) decided to give residents bed (sponge) baths. The issue with the cold water was resolved about 2 weeks ago. Residents started to complain about the water being cold and not wanting to take around the middle of December. There was no hot water from the middle of December until early March in the resident care areas. Infection control Preventionist (ICP) got us big barrels of warm water, and we placed them in the shower rooms in order to offer sponge baths in the shower rooms. R #9 refused sponge baths.G. On [DATE] at 3:30 pm during an interview with Maintenance Director, (MD) stated It takes it a while for the hot water to kick in the shower room. The part that we needed to fix the problem with the cold water in the facility was on back order and that is why it took so long to get it fixed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, and interview, the facility failed to ensure unused medications were properly disposed of on the north hallway, when two medications were observed in the trash bin attached to the medication cart. This deficient practice is likely to affect any resident that may acquire and ingest the medication causing potential medication side effects. The findings are: A. On 03/25/26 at 8:27 am, during an observation of the north hall nurses station, two medications were found in the trash bin attached to the medication cart. Further observation revealed these medications were: a round blue pill stamped with 61, and an oblong orange pill stamped with 20 were together inside an unlabeled medication cup. B. On 03/25/26 at 8:28 am, interview with Registered Nurse (RN) #1, she confirmed those medications were in the trash bin. She also stated unused medications should be disposed in the drug buster (sealed container used for drug disposal) that is located on the bottom drawer. C. On 03/25/26 at 8:34 am, during an interview with the Unit Manager (UM), he stated all unused medications are to be disposed using the drug buster and it did not happen. The UM also stated if the medications are controlled like narcotics then two licensed personnel are to dispose the medication together and updated on the narcotic count sheet.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure staff properly stored and secured medications for all residents residing on the north hallway when a medication cart was left unsecured and unattended. This deficient practice is likely for unauthorized personnel to have access to medications that could result in injury or overdosing. The findings are: A. On 03/24/26 at 9:06 am, during an observation of the north hall, a medication cart was left unlocked and unattended outside of room [ROOM NUMBER]. B. On 03/24/26 at 9:08 am, interview with License Practical Nurse (LPN) #2, she confirmed her medication cart was unlocked and unattended. LPN #2 also stated she should have locked her cart prior to answering the call light. C. On 03/24/26 at 3:37 pm, interview with the Director of Nursing (DON), she stated medication carts should be always locked when nurses are away from the medication cart. The DON further stated it is also an expectation for nurses to keep medication carts and treatment carts locked when not in use.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents were served meals consistent with posted menus and food preferences for 3 (R #7, R #12, R #14) of 3 (R #7, R #12, R #14) residents reviewed:R #7 received food that they are allergic to.R #14, R #12, and R #7 did not receive food according to their meal ticket.These deficient practices have the potential to make resident feel unheard, or have an allergic reaction. The findings areR#7 A. Record review of R #7's face sheet revealed R #7 was admitted to the facility on [DATE] with the diagnosis of an allergy to chocolate.B. On 03/26/26 at 12:16 pm, during an observation of lunch, R #7's lunch ticket revealed that R #7 is not to have any chocolate. R #7 was observed to have been served and was eating chocolate ice cream. C. On 03/26/26 at 12:18 pm. during an interview, Licensed Practice Nurse #1 (LPN # 1) stated R #7 is allergic to chocolate and she should not be eating it. D. On 03/26/26 at 12:22 pm, during an interview, Nutrition Director #1 (ND #1) stated that the meal ticket states that she should not have chocolate; ND #1 served R #7 chocolate ice cream and after R #7 requested ice cream. ND #1 stated he had not read that she was allergic to chocolate.R #12E. Record review of R #12's face sheet revealed R #12 was admitted to the facility on [DATE] with the diagnosis of Hypokalemia;(a condition characterized by low blood potassium levels).F. Record review of R #12's Minimum Data Set (MDS) revealed R #12 is to ha a regular/liberalized pureed diet. G. On 3/26/26 at 11:42 am, during an observation of lunch, R #12's lunch ticket revealed that R #12 is on a pureed diet. R #12 received whole Mandarin oranges not pureed.H. On 03/26/26 CNA #2 confirmed that R #12's dessert (mandarin oranges) were whole and not pureed. R #14I. Record review of R #14's meal ticket revealed R #14 have a grilled Swiss sandwich. Upon observation of R #14's food tray, his sandwich was not grilled.J. On 03/26/26 at 12:22 p.m. While interviewing CNA #2 and DM #1 they confirmed that R #14's sandwich was not grilled. R #14's meal ticket states that it should be grilled.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation, and interview, the facility failed to protect residents' personal health information (PHI) by leaving a document unattended containing multiple residents' information (such as names, diagnoses, treatment plans, or room numbers) on top of a south nurse's counter. This deficient practice is likely to result in passerby's to have unauthorized access to sensitive information, putting residents' privacy at risk. The findings are: A. On 03/16/26 at 9:04 am, during an observation of the south nurse's station, a piece of paper on a clipboard with complete residents information (full name, assigned room number and code status) was left unattended and exposed to public view. B. On 03/16/26 at 9:06 am, during an interview with Registered Nurse (RN) #2, he confirmed the list contained resident's list, assigned room number and their code status was left exposed to public view and unattended. RN #2 confirmed that personal health information should not be left unattended.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and staff interview, the facility failed to ensure that food service equipment was handled in a manner that prevents the spread of infection when the lunch return cart containing uncovered, soiled food trays and dishes sitting unattended in the main hallway outside of the activity room. This deficient practice is likely to expose all residents to potential pathogens (germs) associated with food waste. The findings are: A. On 03/24/26 at 12:58 pm, during an observation of the hallway outside the activity room, a lunch tray return cart containing soiled food trays, dishes, and uncovered was sitting unattended. B. On 03/24/26 at 1:06 pm, during an interview with the housekeeping/laundry manager (HLM), she confirmed she saw the return cart unattended. C. On 03/24/26 at 1:08 pm, during an interview with the Dietary Manager (DM), he confirmed lunch return cart should only be left in the designated area such as by the nurse's station and inside the kitchen. He stated he is not sure why someone would leave the cart uncovered and unattended. He also stated it should be returned to the kitchen for cleaning as soon as all the trays have been picked up and it did not happen in this case.</p>		