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 04/08/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #1) of 2 (R #1 and R #4) residents reviewed for respiratory care when the facility failed to:1. Ensure medical orders indicated when to administer R #1's oxygen.2. Change the oxygen tubing on R #1's portable concentrator (a medical device that provides extra oxygen) and nebulizer (device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or mask).These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their conditions. The findings are:A. Record review of R #1's Face Sheet revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:1. Systemic lupus erythematosus (SLE; a chronic autoimmune disease),2. Morbid obesity (severely overweight),3. Chronic respiratory failure (condition where lungs cannot adequately exchange oxygen and carbon dioxide) with hypoxia (not getting adequate oxygen), 4. Cor pulmonale (right-sided heart failure),5. Hypertension (high blood pressure).B. Record review of R #1's physician orders revealed:1. An order dated 04/26/26 for Ipratropium-Albuterol Solution (a combination medication used to improve breathing) 3 milliliters (ml) to inhale orally three times a day for persistent congestion for seven days.2. No order for supplemental oxygen.C. On 04/08/26 at 10:09 am during a random observation of R #1's room revealed:1. R #1 was wearing a nasal canula (flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) connected to a portable oxygen concentrator (medical device designed to provide supplemental oxygen). The nasal cannula was not dated.2. A nebulizer machine was on top of her dresser with tubing and a mask. The tube was not dated.D. On 04/08/26 at 10:11 am during an interview with Certified Nurse Aide (CNA) #1, She confirmed R #1 was wearing oxygen. She confirmed neither tubing connected to the concentrator and the nebulizer was dated and should be.

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 04/08/2026
NAME OF PROVIDER OR SUPPLIER Casa Real		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Galisteo Street Santa Fe, NM 87505	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation and interview, the facility failed to ensure nursing staff were competent to provide nursing related services for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) due to the Infection Preventionist's (IP) lack of understanding of Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities) requirements for PPE use. This deficient practice is likely to affect all residents that have pressure ulcers and/or wounds by increasing the risk of infections due to repeated and ongoing exposure of infections. The findings are: A. On 04/07/26 at 1:52 pm, an observation of R #1's wound care (cleaning, dressing, monitoring, and evaluation of a wound) in her room revealed:1. No signage posted indicating R #1 required EBP.2. PPE was not readily accessible to perform activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care, wound care, or high contact resident care activities for R #1.B. On 04/07/26 at 1:52 pm, Licensed Practical Nurse (LPN) #1 was observed providing wound care for R #1 without donning a gown before performing a high-contact treatment.C. During an interview on 04/07/26 at 2:00 pm LPN #1 stated she was unaware that gowns were required for all wound care and reported the IP had instructed staff that gowns were only needed for residents on transmission-based precautions (TBP, used to prevent the spread of infectious agents from individuals who are suspected to be infected. Includes contact precautions, droplet precautions, and airborne precautions. Examples are wearing gloves, face masks, and gowns or using disposable equipment).D. On 04/08/26 at 10:20 am during an interview with the IP, she stated that EBP is not needed for all residents that have a pressure ulcer or a wound, it is only needed for residents that have an infected wound.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment (to prevent the development and transmission of communicable diseases and infections) for 1 (R #1) of 3 (R #1, R #2 and R #3) residents, when: 1. The facility failed to post the required Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities) signage for R #1.2. The facility failed to ensure staff utilized EBP during high contact resident care activities.This deficient practice is likely to affect all residents that have pressure ulcers and/or wounds by increasing the risk of infections due to repeated and ongoing exposure of infections. The findings are: The findings are: A. Record review of R #1's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnosis:1. Sepsis (a serious condition in which the body responds improperly to an infection),2. Morbid obesity (severely overweight),3. Cutaneous abscess of abdominal wall (localized infection characterized by a collection of pus within the layers of the skin in the abdominal area).B. On 04/07/26 at 12:15 pm, an observation of R #1's room revealed:1. No signage posted indicating R #1 required EBP.2. Personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) was not readily accessible.C. Record review of R #1's physician orders revealed the following:1. An order dated 03/23/26 for wound care for an unstageable pressure ulcer [a wound that has full thickness tissue loss but is covered with slough (dead tissue) or eschar (dark scab or falling away of dead skin) so that the true depth of the wound cannot be determined] on R #1's sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis).2. An order dated 02/19/26 to check the placement and proper suction of the wound vac to R #1's abdomen.D. Record review of R #1's care plan revealed the following focus areas:1. A focus area dated 02/19/26, R #1 is at risk for skin breakdown related to decreased activity, incontinence, limited mobility, recent surgery, refusals to get out of bed or stay in wheelchair, abdominal surgery of abscess, and has a wound vac in place.2. A focus area dated 02/19/26 for nutritional risk due to advanced age, multiple diagnoses including respiratory failure, HTN, lupus, morbid obesity, increased nutrient needs for wound healing.3. A focus area dated 03/19/26, stating R #1 has an actual infection and a surgical wound.E. On 04/07/26 at 1:52 pm, an observation of R #1's wound care (cleaning, dressing, monitoring, and evaluation of a wound) in her room revealed Licensed Practical Nurse (LPN) #1 provided wound care for R #1 without donning a gown before performing the treatment.F. During an interview on 04/07/26 at 2:00 pm, LPN #1 stated she was unaware that gowns were required for all wound care and reported the Infection Preventionist (IP) had instructed staff that gowns were only needed for residents on transmission-based precautions (TBP, used to prevent the spread of infectious agents from individuals who are suspected to be infected. Includes contact precautions, droplet precautions, and airborne precautions. Examples are wearing gloves, face masks, and gowns or using disposable equipment).G. On 04/08/26 at 10:20 am during an interview with the IP, she stated that EBP is not needed for all residents that have a pressure ulcer or a wound, it is only needed for residents that have an infected wound.