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	06/24/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review and interview, the facility failed to ensure a resident was free from physical restraints for 1 (R #1) of 2 (R #1 and #2) residents when staff failed to assess the resident for the use of a seatbelt. If staff do not assess residents before implementing the use of a seatbelt, then residents may experience injury, entrapment, or a decline in independence and participation. The findings are:A. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/07/26, revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. B.ˆRecord review of R #1's care plans revealed, R #1 the following: - admission date of 06/05/19. - Diagnoses included long term use of anticoagulants, muscle weakness, hemiplegia and hemiparesis following a stroke affecting the left non-dominant side. - Focus: ADL care due to left sided hemiplegia. Intervention, dated 05/26/26, the resident wanted a seat belt to his motorized wheelchair. Staff to assist with putting on the seat belt, but the resident could release the belt himself. This was evaluated by therapy. - Focus: At risk for falls. Intervention, dated 05/26/26, resident fell asleep in his wheelchair. Therapy evaluated him for a seat belt per his choice for safety. The resident required assistance to put the seat belt on, but he was able to release the seat belt. Staff encouraged the resident to use his bed, but his choice was to stay/sleep in his wheelchair or recliner. - Focus: At risk for falls. Intervention, dated 06/10/26, resident fell out of his wheelchair while sleeping, and he was sent to the emergency room due to hitting his head and use of blood thinner. The resident is on the occupational therapy caseload, and physical therapy will also place him on their caseload. Educate the resident on his seatbelt at nighttime for his safety. Resident refused to use the seat belt. He reported it was uncomfortable. C. Record review of R #1's Interdisciplinary Screen Form, dated 05/26/26, revealed the following: - The purpose of the Interdisciplinary Therapy Screen is to provide residents with the opportunity to receive therapy services if functional impairments and potential risks are present and skilled services are required. - Information regarding the resident's current functional status was obtained via resident observation, staff interviews, and chart review. - Reason for the screening: Resident fall. - The resident reported a fall from his wheelchair after falling asleep and hitting his head. - The resident's wheelchair was motorized and has a built-in lap belt. - The resident reported he used the seat belt before, but he often forgets it was on. He stated the seatbelt impedes some activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). - Therapy staff reviewed the resident's status in cognition, swallowing, self-care, mobility, pain, skin conditions, and positioning. Staff documented the resident did not have any change of status in these areas. - Staff recommend and ordered occupational therapy, wheelchair specialist, or nursing staff to evaluate to determine if the restraint (seat belt) was appropriate. D. Record review of R #1's Occupational Therapy (OT) notes revealed the following: - Dated 06/08/26, OT evaluation completed to address if a new power wheelchair was indicated since the resident currently had a wheelchair which was a poor fit and increased his risk for falls. Resident fell asleep in his wheelchair during the day, because he tended to prefer being a night owl. - Dated 06/11/26, OT received the okay for a wheelchair (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment to work on tilt in space power wheelchair. Worked on adjusting self in wheelchair to get to the midline. Resident was a heavy leaner to the right side due to left side hemiparesis. E. Record review of R #1's medical record revealed it did not contain an assessment for the use of a seatbelt. F. On 06/23/26 at 11:35ˆam, during an observation, R #1 wore a seatbelt. G.ˆOn 06/23/26 at 11:36ˆam, during an interview, R #1 stated he had two falls, and the facility decided to put a seatbelt on him for safety reasons. R #1 stated he spoke to the Nurse Practitioner (NP) and told her that he did not need a seatbelt. He stated he just needed sleep H. On 06/23/26 at 12:55 pm, R #1 sat in his wheelchair. Further observation revealed his seat belt was buckled and hung loosely on his lap.ˆ I. ˆOn 06/23/26 at 1:04 pm, during an interview, the Director of Nursing (DON) stated R #1 wore a seat belt, because he always wanted to be in his wheelchair. The DON stated therapy staff evaluated the resident for use of the seat belt due to his increased fall risk. The DON was unable to locate the resident's assessment for the use of a seatbelt. J. On 06/23/26 at 3:25 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated she updated R #1's care plan after his fall. LPN #1 stated she was told during a morning meeting that R #1 wore a seatbelt while in his wheelchair. LPN #1 stated she was not aware if therapy staff completed an assessment. She stated she just assumed therapy staff completed the assessment before the resident utilized the seatbelt. K. On 06/24/26 at 1:50 pm, during an interview, Occupational Therapist (OT) #1 stated the last time staff completed an assessment for R #1's wheelchair seat belt use was in 2025.ˆ OT #1 stated if a resident had to use a seat belt, then therapy should assess the resident quarterly. OT #1 stated the seat belt slipped her radar, and she did not assess R #1 for the use of a seat belt. OT #1 stated she did not complete an assessment of R #1 for the seatbelt, and she could not find an assessment completed by another therapist for the seat belt.ˆ L. On 06/24/26 at 2:04 pm, during an interview, the Director of Rehabilitation (DOR) stated R #1 had a fall on 05/23/26 and 06/08/26, and therapy staff screened (a preliminary tool used to determine if an assessment should be completed) him after the falls. The DOR stated the Speech and Language Pathologist (SLP) recommended the use of a seat belt and for staff to complete an assessment to determine if the use of aˆrestraint was appropriate. The DOR stated staff should have completed a follow-up assessment to determine if it was safe for R #1 to use a seatbelt.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interviews, the facility failed to ensure a prescribed medication was kept out of reach and unavailable to 1 (R #1) of 1 (R #1). If the facility does not keep medications protected from unauthorized access, then residents are at risk of accessing the medication, medicating without physician orders, and experiencing adverse effects. The findings are:A. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/07/26, revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. B. On 06/23/26 at 11:36 am, during an observation of R #1's room, a tube of Mupirocin (topical antibiotic used to treat skin infections), sat on top of the dresser unattended and readily accessible. Further observation revealed the medication was prescribed for R #1 on 04/16/26. C.ˆRecord review of R #1's Authorization of Self Administration of Drugs, dated 06/15/26, revealed, R #1 did not want to self-administer medications. D. On 06/23/26 at 12:28 pm during an interview, the Nurse Practitioner (NP) stated she did not know why the medication was left in the resident's room. The NP stated medications should not be left in resident rooms. E. On 06/23/26 at 12:55 pm during interview, R #1 stated the Mupirocin was prescribed to him, and it was in his room since April 2026. He stated he did not know why it was in his room. F. On 06/23/26 at 1:04 pm during an interview, Director of Nursing (DON) stated R #1 did not have an order to self-administer medication. The DON stated it was not acceptable for a resident to have any type of medication in their room unless they had a self-administer assessment. The DON state R #1 did not have an authorization to self-administer medication. The DON stated medications should be kept under lock and key, and only medical staff should have access to the medications.