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	07/16/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on interview and record review, the facility failed to promote resident self-determination through support of resident choice for 2 (R #'s 36 and 89) of 2 (R #'s 36 and 89) residents reviewed for choices by not accommodating R #36 and R #89's choice to have privacy with each other. If the facility is not honoring resident's choices, then residents are likely to have an increase in frustration and depression. The findings are: A. On 06/24/24 at 2:18 PM during an interview with R #89, she stated it is hard to find privacy here. I have a friend (male) and we were told that we could have privacy but it's yet to happen. We are not even allowed to nap together. B. On 06/26/24 at 9:17 PM during an interview with R #36, he stated the he was in a relationship with R #89, and they cannot go into each other's room. We were told they were going to have a private space for us, but the facility has not provided one. We like to take naps together. When R #36 was asked how it made him feel when they don't have private time. R #36 stated We don't want to cause any trouble, and bet kicked out. C. On 06/26/24 at 9:23 PM during a second interview with R #89, she stated Yes, we (R #36 and R #89) are a couple. We would like private time. We have requested private time, and we are still waiting. I was told if you need to be intimate you just ask staff, and a private place would be provided. We're concerned about breaking the rules. Both residents (R #39 and #89) consent to being in a relationship and feel that they are capable of making that decision. D. On 06/28/24 at 11:27 AM during an interview with the Social Services Director (SSD) she stated that R #89 was able to make decisions about her own care. She is in a relationship with R #36. She further stated that R #89 and R #36 have asked to have a private space on or about May 24, 2024. We (SSD and the past administrator) were either going to try to look for a room for them to start cohorting together or the administrator suggested when the roommate was not in the R #36's room (because she usually goes to the male's room) then they can have their privacy in that room. E. On 07/01/24 at 10:48 AM during interview with Licensed Practical Nurse (LPN) #1, she stated that R #36 had never said that they are a couple, but they have stated that they want to get married. She further stated R #89 and R #36 act like a couple not just friends. R #36 had never asked to have privacy. (continued on next page)

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
	325038	A. Building B. Wing	07/16/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #89's Quarterly Minimum Data Set (MDS-resident identification information) assessment dated [DATE] revealed that R #89 had a Brief Interview for Mental Status (BIMS) (a tool used to screen and identify the cognitive (mental activities like learning, thinking and understanding) condition of residents) score of 10 (cognition level 0 low-15-high). G. On 07/01/24 at 11:14 AM during an interview with Certified Nursing Assistant (CNA) #4 she stated that R #89's was in a relationship with R #36. CNA #4 further stated that they are together all the time. They sit and watch movies together in the common area and sit outside in the courtyard a lot. They are not allowed to be in each others room. H. On 07/01/24 at 11:16 AM during interview with CNA #6, she confirmed that R #89 and R #36 are in a relationship. She stated that they are not allowed to be alone in either ones room when the roommates are there. If they have asked for privacy there was not a room/place for them. I. On 07/01/24 at 11:20 AM during interview with CNA #2 she stated Yes, R #89 and R #36 are in a relationship. They do everything together, eat meals, watch television in the common area, sit outside in the courtyard and sit together at activities. As far as I know, they are not allowed to be alone in their room. We (CNAs) were told by the nurses. I've never heard of a room for residents to have privacy, if there's one I don't know where it is. J. On 07/01/24 at 1:07 PM during an interview with Nurse Practitioner (NP) #1, she stated that R #36 was stable and has not had any aggressive encounters in quite some time. LPN #1 further stated that in her professional opinion R #36 was able to make decisions about being in an intimate relationship. It should be mutually decided. K. On 07/01/24 at 1:29 PM during interview with Physician Assistant (PA) #1, she stated that she was aware of the relationship between R #36 and R #89. She further stated R #89 was generally stable and can make decisions to be in a relationship. She should have the same rights as other couples in the facility do.

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	07/16/2024

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47031 Based on record review and interview the facility failed to provide 1(R #21) of 1 (R #21) resident with their medical records when requested. By not providing the resident with his medical record, the facility is not supporting resident's right to access their records, preventing them from knowing about their medical care and obtaining necessary services. The findings are: A. Record review of R #21's face sheet dated 07/2/2, revealed R #21 was admitted to the facility on [DATE]. The face sheet also revealed that R #21 was responsible for himself. B. On 06/24/24 at 3:11 PM during an interview with R #21, he stated that he had contacted the facility's Director of Nursing(DON) and requested a copy of his medical records approximately two months prior (05/24). R #21 stated that as of the date of this conversation (06/24/24), R #21 had not received his medical records. R #21 stated he has had several conversations with the past Administration. , C. On 06/24/24 at 4:30 PM during an interview with the Administrator he confirmed that he was not employed at the time of R #21 request. He further stated that residents should have access to their medical records at any time.

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	07/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34439 Based on record review and interview, the facility failed to: 1. Ensure facesheet matched the advanced directives document [legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions] in the medical record for R #86. 2. Ensure R #100's advanced directive document was available and in her medical chart. 3. Ensure advanced directive that was in the advanced directive book at the nurses station matched what was in the medical record for R #114. If the facility is not ensuring that each resident has the opportunity to execute an advanced directive, then residents are likely not to have their wishes carried out if there is a time when they are not able to make their own healthcare decisions. The findings are: R #86 A. Record review of MOST form (Medical orders for scope of treatment) for R #86 dated 04/18/24 revealed Full Code (attempt resuscitation). B. Record review of the Physician's order dated 05/09/24 revealed R #86 had Do not Resuscitate (DNR) C. On 06/24/24 at 3:50 PM during an interview with Minimum Data Set (MDS) Coordinator, she confirmed that all of R #86's paperwork in the medical chart and facesheet revealed DNR and the MOST form revealed Full Code. R #100 D. Record review of R #100's facesheet revealed Full code (medical personal would do everything possible to save your life in a medical emergency). E. Record review of the Physician's order dated 04/24/24 revealed R #100 was Full Code. F. Record review of R #110's medical records revealed advanced directive for R #100 was not in R #100's medical record. G. On 06/24/24 at 10:12 am, during an interview with the MDS Coordinator, she confirmed R #100 did not have a code status in the medical chart. R #114 H. Record review of R #114's facesheet revealed DNR. (continued on next page)

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	07/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of the Physician's order dated 06/20/24 revealed R #114 was DNR. J. Record review of advanced directive dated 10/19/23 revealed R #114 was Full code. K. On 06/27/24 at 4:44 PM during an interview with the MDS Coordinator, she stated, R #114 was a full code but, now R #114 was a DNR as per the physicians orders. MDS Coordinator confirmed all R #114's documents in the medical record revealed full code and it (advanced directive) should be changed to reflect DNR.

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	07/16/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on record review and interview, the facility failed to ensure that 1 (R #34) of 1 (R #34) resident reviewed for urinary tract infections (UTI) had a sufficient change assessment (a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions) completed within 14 days of determining the status change was significant. This deficient practice could likely result in residents not receiving the care and assistance needed. The findings are: A. Record review of R #34's Admission record indicated an original admitted [DATE]. with the following diagnosis: 1. Chronic Kidney Disease(CKD), Stage 4 (Stage 4 kidney disease is the last stage before kidney failure). 2. Type 2 Diabetes (a chronic condition where the pancreas produces little or no insulin) 3. Hypercalcemia (a condition in which the calcium level in the blood becomes too high). 4. Hyperthyroidism (when the thyroid gland makes too much thyroid hormone speeding up the body's metabolism) B. Record review of R #34's Care Plan dated 11/14/22, reveled that R #34 had a history of UTI's and was at risk for dehydration due to diuretic therapy (medications that lower blood pressure by increasing urine output) and CKD. Interventions on care plan stated: Monitor for signs/symptoms of dehydration (abnormal water loss from the body), encourage resident to consume all fluids during meals, offer/encourage fluids of choice. C. Record review of the progress notes revealed that R #34 was seen by Nurse Practitioner (NP) on the following dates: - 06/04/24 NP note stated Somnolence (sleeping for unusually long periods), Malaise (lack of energy) - Provider Note dated 06/04/24 stated Difficult to wake, does not respond to voice, delayed, non-spontaneous(reaction does not take place on its own, requires stimulation) response to touch/pain. Staff state resident reports not feeling well, lacking in energy, and not eating as much. Order labs, UA (urinalysis) with C&S(Culture and Sensitivity) to assess for possible infective process causing above symptoms. (continued on next page)

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	07/16/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 06/05/24 NP note stated UA showed bacteriuria (bacteria in the urine), pyuria(excess of white blood cells or pus in urine.) Peripheral IV (PIV catheter that is inserted into a vein to deliver medication, blood or fluids into the bloodstream) ordered last night for IV fluid infusion but has not been completed. Likely has a UTI, but primarily suspect dehydration in the setting of hypercalcemia. Nurse to try today. Resident is seen sitting on her WC (wheel chair), crying, anxious, does not respond to questions. V/S WNL (vital signs within normal limits). - 06/07/24 NP note stated:Peripheral IV insertion for IV fluids ordered 2 nights ago but has not been completed by nursing. Suspect UTI, dehydration in the setting of hypercalcemia. Has not been started on antibiotics (drugs that treat bacterial infections) due to dehydration and CKD. Plan to start when resident has at least been given some fluids to flush out kidneys. - 06/09/24 Nursing note stated IV attempted by myself and RN (registered nurse). Only 1 extension tubing (tubing used for IV insertion) was found and that IV attempt was unsuccessful. Will pass on to oncoming nurse. - 06/10/24 Nursing note stated Resident continues with IV site infusing NS @50 ml/hr (normal saline infusing at 50 milliliters per hour). No s/sx (signs or symptoms) of infiltration (the leakage of non-irritating fluids or medications into the tissues) or overload (receiving too much IV fluid). No redness. Denies pain or discomfort. Continue POC (Plan of Care). - 06/12/24 NP note stated Received fosfomycin (antibiotic used to treat bacterial infections) and IV fluids, 2000 ml (milliliter) with improvement. D. On 07/01/24 at 11:50 am during interview with the Director of Nursing (DON), she confirmed that a Change of Condition Assesment should have been completed for R #34 and this was not done.

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	07/16/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47091 Based on record review and interview, the facility failed to ensure that 3 (R #45, 85 and 100) of 3 (R #s 45, 85 and 100) residents reviewed for Pre-Admission Screening and Resident Review (PASRR) (assessment screen performed prior to admission to evaluate resident for mental illness or intellectual disability) identified as having a primary diagnosis of Dementia, received a Dementia waiver. The waiver would exclude these residents from needing a Level 2 screen (an in depth assessment for mental health illness). The Dementia waivers were not obtained by the facility and Level 2 PASRR screenings were not completed. This deficient practice could likely result in residents with physical or intellectual disabilities not receiving appropriate services after admission to the facility. The findings are: R #45 A. Record review of R #45's medical record revealed a Level II PASRR was not completed due to diagnosis of dementia. This indicated that R #45 needed a Dementia waiver, the record did not contain a Dementia waiver. B. On 06/28/24 at 12:25 pm during interview with Social Services Director (SSD) after reviewing R #45's medical record, she stated that R #45 does not have a Dementia waiver and that R #45 should have one. R #85 C. Record review of R #85's medical record revealed a Level II PASRR was not completed due to diagnosis of dementia. This indicated that R #85 needed a Dementia waiver, the record did not contain a Dementia waiver. D. On 06/28/24 at 12:35 pm during interview with SSD after reviewing R #85's medical record she stated that R #85 does not have a Dementia waiver and that R #85 should have one. R #100 E. Record review of R #100's medical record revealed a Level II PASRR was not completed due to diagnosis of dementia. This indicated that R #100 needed a Dementia waiver, the record did not contain a Dementia waiver. F. On 06/28/24 at 12:45 pm during interview with SSD after reviewing R #100's medical record she stated that R #100 does not have a Dementia waiver and R #100 should have one.

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	07/16/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review, and interview, the facility failed to ensure staff revised the care plan for 2 (R #'s 1 and 7) of 2 (R #'s 1 and 7) residents reviewed when staff failed to: 1. Update the care plan to include oxygen (O2) usage for R #1. 2. Update the care plan to remove restorative nursing services (person-centered nursing care designed to improve or maintain the functional ability of residents, so they can achieve their highest level of well-being possible) for R #7. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's physician order dated 08/19/23 revealed R #1 had an order to wear O2. C. On 06/25/24 at 10:48 am during an interview with R #1, R #1 was observed wearing O2. R #1 stated she wears O2 often. D. Record review of R #1's care plan dated 06/17/24 revealed R #1 did not have O2 use care planned. E. On 06/30/24 at 1:24 pm during an interview with the Minimum Data Set Coordinator (MDSC), she stated that she helped create care plans for residents and R #1's O2 use should be care planned, but it was not. R #7: F. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. G. Record review of R #7's care plan dated 05/19/24 revealed, Focus: [Name of R #7] is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility, pain and polypharmacy [simultaneous use of multiple medications]. Interventions: Restorative nursing program for strength, exercises and ambulation [walk; move about]. H. On 07/03/24 at 1:44 pm during an interview with the Director of Nursing (DON), she stated the facility does not have a restorative nursing program and R #7's care plan was not updated, and should have been.

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	07/16/2024

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 0661 Level of Harm - Actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 41988 Based on record review and interview, the facility failed to provide a discharge summary and post discharge plan of care which included wound care for 1 (R #50) of 1 (R #50) residents reviewed for wounds. This deficient practice likely resulted in R #50's pressure wound worsening and needing emergency care in the hospital. The findings are: Cross reference to F686 A. Record review of R #50's facility wound evaluations (of the same document type), completed by the Wound Care Nurse, revealed on 01/03/24, R #50's left heel pressure ulcer measured 2.6 cm length and 1.43 cm width. B. Record review of R #50's nursing progress notes, dated 01/05/24 at 2:42 pm, revealed R #50 was discharged with all medications to live with her niece. Further review revealed staff did not document they gave wound care instructions to R #50 prior to discharge. C. Record review of R #50's hospital documentation, dated 01/07/24, revealed R #50 went to the emergency room (ER) for an evaluation of a non-healing left foot ulcer with erythematous (reddening of the skin) margins and purulent discharge with concerns for osteomyelitis (infection in the bone caused by bacteria or fungi.) R #50 was consulted and had a left below knee amputation on 01/12/24. D. On 06/24/24 at 12:18 pm during an interview with R #50, she stated the facility did not routinely assess and treated her left foot, which led to it becoming infected. R #50 stated an ambulance took her to the ER in January 2024 for an evaluation, because her foot smelled badly. R #50 stated she was not given any discharge documents. E. On 07/02/24 at 11:34 am during an interview with the Social Services Director (SSD), she stated the previous SSD should have discharged R #50 with a discharge packet, but she did not. The SSD stated when a resident is discharged , the facility nurses will document wound care instructions and medications in the nursing discharge summary, a discharge assessment will be completed and any referrals for home health services if needed. The SSD stated none of that occurred for R #50. F. On 07/02/24 at 11:58 am during an interview with the Wound Care Nurse (WCN), she stated she never spoke to R #50's Niece when R #50 was discharged in January 2024. The WCN confirmed she would expect the facility nurses to educate R #50 on wound care prior to discharge and should have provided R #50 with the appropriate wound care instructions in January 2024. G. On 07/02/24 at 12:40 pm during an interview with R #50's niece, she stated she helped R #50 on the first night R #50 was with her. She stated R #50's left heel pressure ulcer was black and had a distinctly bad smell coming from it. R #50's Niece stated R #50 wanted to go to the hospital so they called 911. She stated an ambulance took R #50 to the hospital for her left heel pressure ulcer, which resulted in a left lower leg amputation. R #50's niece confirmed that when R #50 was discharged home with her, the facility did not provide any instructions related to wound care. (continued on next page)

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	07/16/2024

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 0661 Level of Harm - Actual harm Residents Affected - Few	H. On 07/03/24 at 4:48 pm during an interview with the Director of Nursing (DON), she stated R #50 should have been discharged with specific wound care instructions in January 2024, but she was not.

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	07/16/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 46064 Based on record review, and interview, the facility failed to ensure the residents' ability to perform activities of daily living (ADLs) was maintained for 1 (R #75) of 1 (R #75) resident reviewed for restorative therapy (Restorative services refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible). If the facility does not ensure that residents receive restorative services, then the residents are likely to experience a decrease in their ability to walk, transfer, and do other activities of daily living. The findings are: A. Record review of care plan for R #75 revealed R #75 was at risk for falls due to impaired mobility and weakness related to recent surgery of right knee and history of polytrauma secondary to motor vehicle accident. B. Record review of R #75's clinical orders indicated that R #75 was discharged from physical therapy (PT) on 04/26/2024. C. Record review of R #75's clinical orders indicated resident will be on restorative program to continue with strengthening and endurance. Order dated 04/26/24. D. On 06/23/24 at 3:58 PM during an interview with R # 75, she stated that she has had a decline in her ability to walk. R #75 stated I feel like I would benefit from physical therapy. R #75 further stated that she used to go to physical therapy but does not go anymore and doesn't not know why. E. On 07/01/24 at 11:14 AM during interview with Certified Nurse Assistant (CNA) #4, she stated the facility does not have a restorative program anymore. She further stated that R #75 has had a decline, R #75 had been more incontinent (lack of voluntary loss of bladder or bowel control) lately and staying in bed longer then usual. CNA #4 stated she had noticed that R #75 was not as active as before. F. On 07/02/24 at 10:54 AM during an interview with the Director of Therapy, she stated R #75 used a rollator walker (a wheeled walker that provides support and stability for individuals with limited strength, mobility and balance issues) before she came off service. R #75 was not walking independently, she needs stand by assistance or at least supervision. Last date of services were from 02/26/24 through 04/26/24. At the time of discharge R #75 was walking 300 feet with the rollator and contact assist. Director of Therapy, further stated I feel it was not a safe discharge until she can independently walk 1000 feet.

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	07/16/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers for 4 (R #'s 41, 50, 69 and 71) of 4 (R #'s 41, 50, 69 and 71) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #41: A. Record review of R #41's face sheet revealed R #41 was admitted into the facility on [DATE]. B. Record review of R #41's care plan dated 05/07/24 revealed, Focus: [Name of R #41] requires assistance with ADL care/ transfers and mobility r/t [related to] dx [diagnosis] of seizures/ epilepsy/ ESRD [end stage renal disease]/ Hemiplegia [paralysis of one side of the body] R [right]/ Weakness, dialysis, liver cirrhosis, HTN [hypertension- high blood pressure] and generalized weakness. Interventions: One staff assist with showers per schedule and prn [as needed]. She requires physical assistance with bathing. C. Record review of the facility shower schedule revealed R #41 was to be offered/given a bath/shower every Tuesday, Thursday, and Saturday. D. Record review of R #41's documentation survey report (ADL tracking form on electronic health record-EHR) dated 05/01/24 through 05/31/24 revealed R #41 was offered/given four (4) baths/showers out of 13 opportunities. E. Record review of R #41's shower sheets dated 05/01/24 through 05/31/24 revealed R #41 was offered/given two (2) baths/showers out of 13 opportunities. F. Record review of R #41's documentation survey report dated 06/01/24 through 06/30/24 revealed R #41 was offered/given a bath/shower for three (3) out of ten (10) opportunities. G. Record review of R #41's shower sheets dated 06/01/24 through 06/30/24 revealed R #41 was offered/given six (6) baths/showers out of ten (10) opportunities. H. On 06/24/24 at 3:01 pm during an observation and interview with R #41, she had disheveled hair. R #41 stated that she is supposed to be offered and/or receive three baths/showers a week on Tuesdays, Thursdays, and Saturdays. R #41 also stated that she frequently is not offered and/or given a shower due to staff saying they are busy. R #41 confirmed she recently has gone multiple days without a shower and she does not feel good when she is not offered and/or given a bath/shower. I. On 06/30/24 at 2:47 pm during an interview with Certified Nursing Assistant (CNA) #1, he stated R #41 should be offered/given at least three baths/showers per week. (continued on next page)

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	07/16/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 07/03/24 at 1:46 pm during an interview with Director of Nursing (DON), she stated R #41 should be offered at least three baths/showers a week and R #41 was not. DON also confirmed staff should document any bath/shower refusals. R #50: K. Record review of R #50's face sheet revealed R #50 was admitted into the facility on [DATE]. L. Record review of R #41's care plan dated 01/18/24 revealed, Focus: [Name of R #50] requires assistance/is dependant for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to weakness, impaired mobility [.] Interventions: Max assist with showers and alert nurse if nails need to be trimmed since she is diabetic. M. Record review of the facility shower sheet revealed R #50 was to be offered/given a bath/shower on Thursdays and Sundays. N. Record review of R #50's documentation survey report dated 05/01/24 through 05/31/24 revealed R #50 was offered/given a bath/shower for four (4) out of nine (9) opportunities. O. Record review of R #50's shower sheets dated 05/01/24 through 05/31/24 revealed R #50 was offered/given a bath/shower for one (1) out of nine (9) opportunities. P. Record review of R #50's documentation survey report dated 06/01/24 through 06/30/24 revealed R #50 was offered/given a bath/shower for two (2) out of nine (9)opportunities. Q. Record review of R #50's shower sheets dated 06/01/24 through 06/30/24 revealed R #50 was offered/given a bath/shower for four (4) out of nine (9) opportunities. R. On 06/24/24 at 12:00 pm during an interview with R #50, she stated that most of the time she will only receive one shower a week due to staffing. R #50 confirmed she wanted at least two showers a week and she does not feel good when she is only offered one. S. On 06/30/24 at 2:44 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated R #50 should be offered at least two baths/showers a week and CNAs should document resident baths/showers in the EHR and on shower sheets. T. On 06/30/24 at 2:53 pm during an interview with CNA #1, he stated R #50 had missed showers due to staffing. CNA #1 also stated R #50 approached him this morning to complain about her lack of showers and R #50 told him she felt gross and dirty. U. On 07/03/24 at 1:42 pm during an interview with the DON, she stated her expectation was baths/showers are completed and staffing should not be an issue for that. DON confirmed R #50 was not offered enough baths/showers and should have been. R #69: V. Record review of R #69's face sheet revealed R #69 was admitted into the facility on [DATE]. (continued on next page)

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	07/16/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	W. Record review of R #69's care plan dated 06/11/24 revealed, Focus: [Name of R #69] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Recent fall, Weakness, low back pain, hospitalization , dehydration and failure to thrive [.] Interventions: Help with showers of one staff, ensure his nails are cleaned and he is shaved. X. Record review of the facility shower schedule revealed R #69 was to be offered/given a bath/shower on Thursdays and Saturdays. Y. Record review of R #69's documentation survey report dated 05/01/24 through 05/31/24 revealed R #69 was offered/given a bath/shower for four (4) out of nine (9) opportunities. Z. Record review of R #69's shower sheets dated 05/01/24 through 05/31/24 revealed R #69 was offered/given a bath/shower for one (1) out of nine (9) opportunities. AA. Record review of R #69's documentation survey report dated 06/01/24 through 06/30/24 revealed R #69 was offered/given a bath/shower for three (3) out of nine (9) opportunities. BB. Record review of R #69's shower sheets dated 06/01/24 through 06/30/24 revealed R #69 was offered/given a bath/shower for seven (7) out of nine (9) opportunities. CC. On 06/23/24 at 3:39 pm during an interview with R #69, he stated that he was not offered/given baths/showers at least two times a week and he would like that. DD. On 07/03/24 at 1:43 pm during an interview with the DON, she confirmed R #69 was not offered/given enough baths/showers and should have been. 47091 R #71: EE. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. FF. Record review of R #71's care plan dated 03/25/24 revealed, Focus: [Name of R #71] is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion and toileting) related to: Dementia with repeat falls and ataxic(uncoordinated) gait. She requires supervision/set up for grooming, dressing, hygiene and showers. GG. Record review of the facility shower schedule revealed R #71 was to be offered/given a bath/shower every Monday and Thursday. HH. Record review of Grievance reports revealed a grievance was reported to facility administrator on 05/14/24 by R #71's daughter, regarding a concern that resident was not being showered. II. Record review of R #71's documentation survey report dated 03/01/24 through 03/31/24 revealed R #71 was offered/given four (4) baths/showers out of eight (8) opportunities . (continued on next page)

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	07/16/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	JJ. On 07/03/24 at 1:49 pm during an interview with Director of Nursing (DON), she stated that R #71 should have been offered at least two baths/showers a week and R #71 was not. DON also confirmed staff should document any bath/shower refusals.

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	07/16/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 34439 Based on record review and interview, the facility failed to provide an ongoing activity program for 4 (R #12, #51, #66 and #86) of 4 (R #12, #51, #66 and #86) residents reviewed for activities. If the facility is not ensuring that all residents are receiving an ongoing activity program, documenting resident refusals and making in room activity accommodations, then residents are likely to demonstrate an increase in isolation and depression. The findings are: A. Record review of the one on one room visit log provided by the Activities Director (AD) revealed R #12, R #51, R #66, and R #86 were residents that were to receive room visits (activity staff visits) three times a week for social interaction. R #12, R #51, R #66, and R #86 did not like to participate in group activities. B. Record review of R #12's activity attendance logs for April 2024, revealed staff had documented that R #12 had two room visits out of 13 opportunities. In May 2024, R #12 had six room visits with three refusals, one actively involved in activity and two R #12 was asleep, out of 14 opportunities. In June 2024, R #12 did not have any room visits of 12 out of 12 opportunities. C. Record review of R #12's care plan dated 04/10/23 revealed [name of R #12] is at risk for decreased socialization due to current placement in long term care facility [name of R #12] prefers to spend much of his time in his room, but occasionally attends social gatherings such as coffee social and bingo. D. Record review of R #51's activity attendance logs for April 2024, revealed staff documented that R #12 had one room visit and staff marked resident was unavailable for one out of 13 opportunities. For May 2024, staff documented that R #12 had one room visit and staff marked sleeping. June 2024, there were no activity attendance logs available for review. E. Record review of R #66 activity attendance logs for April 2024, revealed staff documented that R #66 had only one room visit. In May 2024, staff documented that R #66 had four (4) unavailable and R #66 was asleep for three opportunities. June 2024, Staff documented that R #66 had two room visits and one refusal for 12 opportunities. F. Record review of R #86 activity attendance logs revealed in May 2024, staff had marked one out of 14 opportunities of activities. June 2024, staff did not document any activities for 12 opportunities. G. On 06/24/24 at 3:19 pm during an interview with R #86, he stated that staff do not get him up often enough and he would like to get up and watch TV, play on his iPad and visit with residents and staff. H. On 07/02/24 at 4:04 PM during an interview with the AD, she confirmed that R #12, # 51, #66 and #86 were all residents that did not attend group activities and were to have room visits three times a week and had not been getting the scheduled visits as they should have been. Room visits are scheduled for Mondays, Wednesdays, and Fridays.

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	07/16/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure residents received bowel movement (BM) monitoring and interventions for 1 (R #31) of 1 (R #31) residents reviewed when staff failed to: 1. Monitor R #31 for constipation (problem with passing stool). 2. Notify the provider R #31's constipation medication was not working and R #31 did not have a BM days before R #31 went to the hospital. This deficient practice likely resulted in R #31 having ongoing constipation, fecal impaction (hardened stool stuck in rectum or lower colon due to chronic constipation), and abdominal pain. The findings are: A. Record review of R #31's face sheet revealed R #31 was admitted into the facility on [DATE] and was discharged to the hospital on 07/01/24. R #31 had the following diagnoses: 1. Chronic Pain. 2. Constipation. B. Record review of R #31's physician orders revealed the following: 1. Order, dated 12/28/22, for sennosides docusate sodium tablet (a laxative; a medication used to treat constipation) 8.6 - 50 milligrams (mg). Give one tablet by mouth one time a day for constipation. 2. Order, dated 07/14/23, for colace capsule (stool softener), 100 mg. Give one capsule by mouth two times a day as needed for constipation. 3. Order, dated 07/15/23 for glycoLax powder (a laxative.) Give 17 grams (g) by mouth one time a day for constipation. C. Record review of R #31's care plan, dated 05/24/24 and updated on 07/02/24, revealed - Focus: R #31 was at risk for gastrointestinal symptoms or complications related to constipation. - Interventions: Monitor and record BM in electronic health record (EHR) daily to include color, size, consistency. Alert nurse if no BM in three days. Nurse Practitioner (NP) to review bowel medication regime for effectiveness due to severe constipation and prevent fecal impaction. Nurse to review bowel movements (BMs) with staff daily. Assess for and report signs and symptoms of nausea or vomiting, abdominal distention (a sensation of increased pressure with swelling in the abdomen), decrease in bowel movements, decrease bowel sounds, and abdominal pain. Monitor and record bowel movements. (continued on next page)

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	07/16/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	D. Record review of R #31's Medication Administration Record (MAR), dated 06/01/24 through 06/30/24, revealed staff administered the following: 1. Sennosides - docusate sodium tablet, 8.6-50 mg, to R #31 every day of the month. 2. Colace capsule, 100 mg, to R #31 twice a day, every day of the month. 3. GlycoLax powder to R #31 every day of the month. E. Record review of R #31's Documentation Survey Report (Activities of Daily Living tracking form), dated 06/01/24 through 06/30/24, revealed staff did not document R #31's bowel movements for the dates of 06/25/24, 06/26/24, 06/27/24, 06/28/24, 06/30/24. Staff documented R #31 had one BM on 06/29/24. F. Record review of R #31's provider progress notes revealed the provider documented the following (Note: Similar type documents combined into one entry): - On dated 06/30/24, the resident's abdomen was distended, firm, and tender with palpation. - On 07/01/24, R #31 was sent to Emergency Department on 06/30/24 for abdominal pain and distention. He had a fecal impaction. G. On 07/03/24 12:47 pm during an interview with Certified Nursing Assistant (CNA) #1, he stated CNAs were to monitor and document R #31's BMs every day. He stated if R #31 did not have a BM, then CNAs were to document that and let the nurses know. CNA #1 also stated R #31 discharged to the hospital two hours into his shift due to a fecal impaction. CNA #1 stated he was off during the days when R #31 did not have a BM, but the CNAs on those shifts should have notified the nursing staff. H. On 07/03/24 at 12:48 pm during an interview with CNA #2, she stated CNAs were to document R #31's BMs in the EHR and to notify nursing staff if R #31 did not have a BM. CNA #2 stated she was unaware R #31 did not have a BM for several days prior, because no one gave her that information. I. On 07/03/24 at 1:16 pm during an interview with the Physician's Assistant (PA) #1, she stated she was notified of R #31's constipation on the day he was sent to the emergency room (ER). She stated if a resident did not have a BM for three days then the nurses were to give the resident PRN medication and to notify her. PA #1 stated CNAs should have documented when R #31 did not have a BM. She stated staff should have notified her of R #31's constipation sooner, and she should be notified if a PRN medication was not working. J. On 07/03/24 at 1:44 pm during an interview with the Director of Nursing (DON), she stated CNAs should have documented R #31's BMs or constipation every day, but they did not. The DON also stated CNAs should notify nursing if a resident did not have a BM in 24 hours, and they will contact the provider if a resident was constipated for three days. The DON confirmed nursing staff is responsible for monitoring a residents EHR to see if a resident does not have a BM. The DON also stated the facility nursing staff should have notified PA #1 of R #31's constipation and that the medications were not working for R #31.

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	07/16/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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; skin damage which results from unrelieved pressure on the body) for 2 (R #50 and #69) of 2 (R #50 and #69) residents reviewed when staff failed to: 1. Timely identify the new wound, monitor for changes in the wound, provide daily treatments as ordered and notify the physician that the wound was worsening for R #50. 2. Complete and document weekly skin evaluations for R #69. This deficient practice likely resulted in R #50's pressure ulcer worsening and leading to an amputation. This deficient practice is also likely to lead to residents developing pressure ulcers and wounds worsening. The findings are: R #50: A. Record review of R #50's face sheet revealed R #50 was admitted into the facility on [DATE]. B. Record review of R #50's Braden Scale for Predicting Pressure Sore Risk (a tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers), dated 10/04/23, revealed R #50 was at risk for developing pressure ulcers. C. Record review of R #50's facility skin checks completed by the facility's Wound Care Nurse (WCN) revealed the following: - On 10/19/23, R #50 had a skin wound to her left rear thigh. No other wounds identified. - On 11/07/23, R #50 refused the skin assessment. D. Record review of R #50's hospital wound care notes, dated 11/23/23 revealed R #50 was sent to the hospital due to a fever and altered mental status, and R #50 was admitted into the hospital. E. Record review of R #50's hospital notes, dated 11/24/23, revealed R #50 had an unstageable [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] posterior (further back in position) eschar pressure injury on her left heel. The hospital notes did not include measurements of the pressure injury. R #50 was also diagnosed with encephalopathy (a disease that affects brain structure or function) and sepsis (an infection in the blood stream) due to a urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra). R #50 was discharged from the hospital on 11/28/23. F. Review of R #50's facility skin check dated 11/29/23, revealed staff documented R #50 had a black pressure ulcer on the left heel. Staff did not document measurements or any other information related to R #50's left heel pressure ulcer. (continued on next page)

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	07/16/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	G. Record review of R #50's facility wound evaluation, dated 11/30/23, revealed R #50's left heel pressure ulcer was unstageable and present on admission with age [of wound] unknown. R #50's left heel pressure ulcer measured 1.53 centimeters (cm) length and 0.96 cm width. H. Record review of R #50's physician orders, dated 11/30/24, revealed an order for wound care to left heel. Paint with betadine (antiseptic medication), cover with heel /foam, wrap with kerlix (bandage), and secure with tape every night shift for unstageable pressure ulcer. R #50's order was discontinued on 01/03/24. I. Record review of R #50's Treatment Administration Record (TAR), dated 12/01/23 through 12/31/23, revealed staff completed R #50's order for wound care to left heel every night R #50 was in the facility. J. Record review of R #50's hospital history and physical documentation, dated 12/07/23, revealed R #50 went to the emergency room (ER) due to R #50 experienced hypoxia (low blood oxygen levels), vomiting, and confusion. R #50's hospital documents revealed R #50 had an unstageable left heel pressure ulcer. R #50 was admitted into theER on [DATE] and discharged back to the facility on [DATE]. K. Record review of R #50's skin and wound evaluations revealed the following: - Two evaluations, dated 12/18/23 (one completed at 12:20 pm and the other completed at 12:23 pm), staff did not document R #50's left heel pressure ulcer on either skin and wound evaluations - One evaluation, dated 12/27/23, staff did not document R #50's left heel pressure ulcer. L. Record review of R #50's facility wound evaluations (of the same document type), completed by the WCN, revealed staff documented the following: - On 12/27/23, R #50's left heel pressure ulcer measured 1.89 cm length and 0.98 cm width. - On 01/03/24, R #50's left heel pressure ulcer measured 2.6 cm length and 1.43 cm width. M. Record review of R #50's medical record revealed the record did not contain an update or change to the wound care orders for the resident's left heel pressure ulcer. N. Record review of R #50's TAR, dated 01/01/24 through 01/05/24, revealed staff completed R #50's order for wound care to left heel one time on 01/02/24. O. Record review of R #50's nursing progress notes, dated 01/05/24 at 2:42 pm, revealed R #50 was discharged with all medications to live with her niece. Further review revealed staff did not document they gave wound care instructions to R #50 prior to discharge. P. Record review of R #50's physician orders, dated 01/05/24 at 6:00 pm [after R #50's discharge], revealed an updated order for wound care to left heel. Cleanse with wound cleanser, pat dry, apply ManukaHD (natural antibiotic) honey to wound bed, and cover with foam dressing every night shift, every other day for unstageable pressure ulcer. There is no evidence in the record that this wound care was provided. (continued on next page)

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	07/16/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Q. Record review of R #50's hospital documentation, dated 01/07/24, revealed R #50 was taken to the ER by ambulance (from R #50's niece's home) for an evaluation of a non-healing left foot ulcer with erythematous (reddening of the skin) margins and purulent (containing pus) discharge with concerns for osteomyelitis (infection in the bone caused by bacteria or fungi). R #50 was consulted and had a below the left knee amputation on 01/12/24. R. Record review of R #50's care plan dated 01/18/24, revealed R #50 was at risk for skin breakdown due to diabetes, compromised skin related to previous multiple open areas, and limited mobility. One intervention was for staff to observe R #50's skin condition daily and report any skin abnormalities. S. On 06/24/24 at 12:18 pm during an interview with R #50, she stated the facility did not routinely assess and treat her left foot, which led to it becoming infected. R #50 stated an ambulance took her to the ER in January 2024 for an evaluation, because her foot was not better. She stated it smelled badly and her left lower leg was amputated as a result of the wound. T. On 06/26/24 at 10:54 am and on 07/02/24 at 11:55 am during an interview with the WCN, she stated R #50 was in and out of the hospital multiple times in 2023 and returned to the facility in November 2023 with an unstageable pressure ulcer to her left heel. The WCN stated she evaluated R #50 weekly as much as she could, but R #50's left heel pressure ulcer began to open and deteriorated from 12/27/23 to 01/03/24. The WCN stated she was asked to work the floor due to short staffing during this time as well. The WCN stated she did not consult a wound care clinic for R #50. She stated R #50 returned to the facility on [DATE], and R #50's left lower leg was amputated. The WCN stated she oversaw the facility's wound care program, but the nurses know they are supposed to complete skin evaluations for residents every week. The WCN also stated every nurse was assigned skin evaluations to complete. She stated completing the skin evaluations has been an on going issue due to staffing and staff turnover. The WCN stated R #50 did not have consistent weekly skin evaluations, and staff documented R #50's left heel pressure ulcer only one time in the weekly skin evaluations. The WCN stated staff should have monitored and documented more frequently for the status of R #50's left heel pressure ulcer. The WCN confirmed R #50's January 2024 TAR indicated the nurses completed wound care for R #50 on 01/02/24, but the nurse should have completed wound care each day R #50 was in the facility. U. On 07/01/24 at 1:05 pm during an interview with Nurse Practitioner (NP) #1, she stated her expectation was for facility nursing staff to check on resident wounds daily, conduct weekly skin evaluations, and document the progress or decline of a resident's wound for providers and the WCN to see. The NP confirmed that she was not aware of the wound worsening and would have liked to be notified sooner. V. On 07/02/24 at 12:35 pm during an interview with R #50's Sister-In-Law (SIL), she stated R #50 went to stay with her niece in January 2024. She stated R #50 was with her niece for one night due to R #50's left heel pressure ulcer smelled really bad and looked infected. The SIL stated R #50's left lower leg was amputated shortly after that. W. On 07/02/24 at 12:40 pm during an interview with R #50's niece, she stated she helped R #50 on the first night R #50 was with her. She stated R #50's left heel pressure ulcer was black and had a distinctly bad smell coming from it. R #50's Niece stated R #50 wanted to go to the hospital so they called 911. She stated an ambulance took R #50 to the hospital for her left heel pressure ulcer, which resulted in a left lower leg amputation. (continued on next page)

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	07/16/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R #69: X. Record review of R #69's face sheet revealed R #69 was admitted into the facility on [DATE]. Y. Record review of R #69's physician orders, dated 03/13/24, revealed an order for a unstageable pressure ulcer to the right heel. Apply sureprep (skin protectant) every day shift for pressure ulcer wound care. Z. Record review of R #69's Electronic Health Record (EHR) revealed nursing staff completed a skin evaluation for R #69 on 05/28/24. Further review revealed the WCN did not complete another skin evaluation for R #69 until 07/02/24. R #69's EHR indicated the WCN did not see R #69's wound from 05/28/24 until 07/02/24. AA. Record review of R #69's care plan, reviewed on 07/02/24, revealed the following: - Focus: R #69 was at risk for skin breakdown. - Interventions: Observe skin for signs and symptoms of skin breakdown, i.e. redness, cracking, blistering, decrease sensation, and skin that did not blanche easily. Observe skin condition daily with activities of daily living (ADLs; personal care activities that most people perform daily) care and report abnormalities. BB. On 07/01/24 at 3:09 pm during an interview with the WCN, she stated nurses should complete a skin evaluation for R #69 weekly, but they did not. Based upon observation, interview, and record review, Immediate Jeopardy was identified on 07/02/24 at 3:43 pm. The facility Administrator and Director of Nursing were notified in person and by e-mail at this time. The facility took corrective action by providing an acceptable Plan of Removal (POR) and implementation was verified onsite on 07/03/24. The scope and severity was reduced to level 2, E. The plan of removal included: 1. On 7/2/24, the nursing team initiated a whole house resident skin sweep to identify all current wounds in the facility and assess for correct identification and treatment. Any identified concerns, including refusals of wound care/assessment and worsening wounds, will include change in condition documentation and notification to the provider and family. Any new orders will be followed. 2. Nurses will be educated on completion of skin assessments on admission and weekly per schedule. 3. Nurses will be educated on their responsibility with communication with management and the change in condition process/documentation when a resident is having a change in condition (including new or worsening wounds). (continued on next page)

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	07/16/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Nurses will be educated on [Name of facility company] wound processes which include the DIMES (Debridement/devitalized tissue, Infection or inflammation, Moisture balance, wound Edge preparation and wound depth), timely and accurate identification and documentation for wounds/wound changes, change in condition process, and appropriate treatment/intervention implementation upon identification of new or worsening wounds. 5. CNAs will be educated on how to minimize pressure, friction and shearing, change in condition process for CNA's (including skin changes) and stop and watch.

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	07/16/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to ensure that 3 (R #'s 7, 63, and 68) of 3 (R #'s 7, 63, and 68) residents reviewed were free from accidents and hazards by staff not: 1. Completing a fall risk assessment and placing a fall mat (specially designed floor mats placed on the floor at the bed or chair to protect the elderly from serious physical trauma) per physician orders for R #7. 2. Completing smoking assessments quarterly for R #'s 63 and 68. 3. Having staff present during smoking times for R #'s 63 and 68. These deficient practices are likely to put residents at risk of unsafe situations. The findings are: R #7: A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. B. Record review of R #7's physician orders dated 02/15/24 revealed, Place fall mat on floor. C. Record review of R #7's care plan dated 05/19/24 revealed, Focus: [Name of R #7] is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility, pain and polypharmacy [simultaneous use of multiple medications]. Interventions: Fall mat on floor when in bed. D. Record review of R #7's Electronic Health Record (EHR) dated 07/03/24 revealed R #7 did not have a fall risk assessment completed (used to determine how severe of a fall risk resident was). E. On 07/02/24 10:31 am during an observation of R #7's room, R #7 laid in bed without a fall mat on the floor. F. On 07/0224 at 10:33 am during an interview with Certified Nursing Assistant (CNA) #3, she stated R #7 was a fall risk. CNA #3 confirmed R #7 did not have a fall mat present. G. On 07/02/24 at 10:39 am during an interview with Licensed Practical Nurse (LPN) #2, she confirmed R #7 was a fall risk because of his limited vision. H. On 07/03/24 at 1:46 pm during an interview with the Director of Nursing (DON), she stated R #7 should have a fall mat per physician orders. I. On 07/03/24 at 3:48 pm during an interview with the Clinical Resource Registered Nurse (CRRN), he stated R #7's care plan was not updated quarterly for R #7's falls and a fall risk assessment was not completed for R #7. (continued on next page)

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	07/16/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #63: J. Record review of R #63's face sheet revealed R #63 was admitted into the facility on [DATE]. K. Record review of R #63's smoking evaluation dated 12/27/23 revealed R #63 required supervision while smoking. R #63 has not had a smoking evaluation completed since 12/27/23. L. Record review of R #63's care plan dated 07/01/24 revealed, Focus: [Name of R #63] may smoke with supervision per smoking assessment. He has been out in courtyard several times smoking unsupervised. Management has addressed the rules with him and he needs close supervision. Ensure he is smoking tobacco only and not Marijuana. Interventions: Inform of and reinforce smoking restriction, Inform family and significant others that the patient needs supervision while smoking. Reassess patients ability to smoke with supervision with any change in condition. Supervise patient with smoking in accordance with assessed needs. M. On 06/24/24 at 10:34 am during an smoking observation, R #63 was smoking in the courtyard with other residents, staff was not present. N. On 06/30/24 at 2:44 pm during an interview with LPN #1, she stated R #63 required supervision when smoking and staff should be out in the courtyard during all smoking times. LPN #1 also stated it is difficult for staff to go outside during smoking times due to staffing issues. LPN #1 confirmed resident smoking assessments should be completed quarterly. O. On 07/03/24 at 1:52 pm during an interview with the DON, she stated CNAs and other staff should be supervising residents during smoking hours. DON also stated R #63 has not has a smoking assessment completed since 12/27/23 and R #63 should have had a smoking assessment completed. R #68: P. Record review of R #68's face sheet revealed R #68 was admitted into the facility on [DATE]. Q. Record review of R #68's smoking evaluation dated 02/19/24 revealed R #68 could smoke independently. R #68 had not had a smoking evaluation completed after 02/19/24. R. Record review of R #68's care plan dated 06/21/24 revealed, Focus: [Name of R #68] may smoke with supervision per smoking assessment. Interventions: Ensure that appropriate cigarette disposal receptacles are available in smoking areas, Lighters or matches must be maintained by center staff; e-cig charging must occur at nurses' station, Monitor compliance with smoking policy, smoking assessments ongoing per policy, supervise patient while smoking for safety. S. On 06/23/24 at 2:38 pm during an smoking observation, R #68 smoked in the courtyard without staff present. T. On 07/03/24 at 1:39 pm during an interview with the DON, she confirmed R #68 has not has a smoking assessment completed since 02/19/24 and R #68 should have had a smoking assessment completed.

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	07/16/2024

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 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure 1(R #34) of 1(R#34) resident reviewed for dehydration maintain adequate hydration when they failed to: 1. Provide IV (intravenous; a thin plastic tube inserted into a vein using a needle) fluid hydration as ordered by a physician for R #34, 2. Document and monitor fluid intake for R #34. This deficient practice likely resulted in R #34 to have prolonged dehydration and worsened an untreated UTI. The findings are: A. Record review of R #34's face sheet revealed R #34 was admitted into the facility on [DATE]. B. Record review of R #34's care plan, dated 05/06/24, revealed the following: - Focus: R #34 was at risk for dehydration as evidence by diuretic (medication used to increase urine output and reduce fluid retention) medication. She had chronic kidney disease (CKD; gradual loss of kidney function) and hypertension (HTN; high blood pressure.) She was cognitively impaired and dependent on staff for fluid intake. She was also on poly-pharmacy (the use of multiple drugs to treat a single ailment or condition) and had poor appetite. - Interventions: Encourage resident to consume all fluids during meals, monitor for signs and symptoms of dehydration [symptoms can include increased temperature, decrease output (of urine or other bodily fluids), mental status changes, dry mucous membranes, orthostatic hypotension (low blood pressure), tachycardia (rapid heart rate)]. Offer and encourage fluids of choice. C. Record review of R #34's physician orders, dated 06/05/24, revealed an order to insert peripheral (away from the center of the body) IV for fluids. One time only for hypercalcemia (high levels of calcium), UTI, and dehydration for three days. D. Record review of R #34's provider progress notes revealed the provider documented the following: - On 06/06/24, peripheral IV ordered last night for IV fluid was not completed. The resident likely had a UTI, but primarily suspected dehydration in the setting of hypercalcemia (elevated calcium levels). Nurse to try on 06/06/24. Hypercalcemia may be resolved with IV hydration. Resident was awake, anxious, and crying. - On 06/07/24, peripheral IV insertion for IV fluids ordered two nights ago but was not completed by nursing. Suspected UTI, dehydration in the setting of hypercalcemia. Was not started on antibiotics due to dehydration and CKD. Plan to start when resident was given fluids to flush out kidneys. E. Record review Documentation Survey Report (Activities of Daily Living Tracking Form in R #34's electronic health record), dated 06/05/24 through 06/10/24 revealed staff documented the following: (continued on next page)

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	07/16/2024

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 0692 Level of Harm - Actual harm Residents Affected - Some	- R #34's urinary output one time on 06/05/24 (which indicated R #34 only urinated one time for the day.) - R #34's urinary output one time on 06/06/24. - R #34's urinary output zero times on 06/07/24. - R #34's urinary output three times on 06/08/24. - R #34's urinary output one time on 06/09/24. - R #34's urinary output three times on 06/10/24. F. Record review of R #34's nursing progress notes revealed staff documented the following: - On 06/09/24, the writer and Registered Nurse (RN) attempted IV. Only one extension tubing (a small and short tube that is added to an existing IV line) was found, and IV attempt was unsuccessful. Passed on to incoming nurse. - On 06/10/24, R #34 received her peripheral IV [five days after the physician's order]. G. Record review of R #34's Documentation Survey Report, dated 06/01/24 through 06/11/24, revealed staff documented R #34 drank a beverage 19 out of 42 opportunities. Further review showed staff did not document any fluid intake on 06/07/24, and staff documented only the night shift drink/snack on 06/09/24. H. On 06/24/24 at 1:50 pm during an interview with R #34's husband, he stated R #34 got very thirsty throughout the day. I. On 06/30/24 at 2:51 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated staff should document whether or not R #34 accepted (drank) fluid for every meal and snack. J. On 07/01/24 at 1:08 pm during an interview with Nurse Practitioner (NP) #1, she stated the facility did not have IV supplies to use on R #34 when she put in the IV order on 06/05/24. NP #1 confirmed it should not have taken five days to administer IV fluid to R #34, and nursing staff should have monitored and documented whether or not R #34 accepted her beverage at each meal and snack. K. On 07/03/24 at 1:46 pm during an interview with the Director of Nursing (DON), she stated the expectation was the nursing staff administered an IV to R #34 after receiving the physician order to do so. The DON stated the nursing staff was not aware of where the IV supplies were and did not look for them. She stated a nurse went to a nearby hospital to retrieve IV supplies for R #34. The DON stated staff should have documented R #34's drink intake for every meal and snack, because that was how the facility tracked fluid intake.

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	07/16/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on interview and record review, the facility failed to ensure ongoing communication forms were completed and collaboration (different persons/groups working together) with the dialysis (clinical purification of blood as substitute for normal kidney functioning) facility regarding dialysis care and services for 1 (R #41) of 1 (R #41) residents reviewed for dialysis. If the facility is unaware of the status, condition, or complications that arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: A. Record review of R #41's face sheet revealed R #41 was admitted to the facility on [DATE] with multiple diagnoses including: End Stage Renal Disease (a progressive disease of the kidneys) Dependence of Renal Dialysis (use and dependence on dialysis to clean and purify blood) B. Record review of R #41's electronic medical record revealed a physician order for R #41 to attend dialysis on Mondays, Wednesdays and Fridays. C. Record review of Dialysis Communication Book at the facility revealed missing communication forms (a form from the dialysis center that indicates dialysis procedures and results of the days dialysis procedure) between the facility and the dialysis center. The book did not have any communication forms for the following dates: 06/05, 06/07, 06/10, 06/12, 06/14, 06/17, 06/21 and 06/26/24. Form dated 06/03/24 was incomplete. D. On 06/27/24 at 10:45 am during interview with Licensed Practical Nurse (LPN) #1, she stated R #41 was sent to dialysis three times a week. After reviewing the communication book LPN #1 confirmed that R #41 had missing communication forms. E. On 06/27/24 at 11:35 am during interview with LPN #1, she stated that facility staff completed the top part of the dialysis communication form. Facility staff will take the residents vitals,and at the dialysis center, dialysis staff will take the residents vitals post (after) treatment and returns the form to the facility. This should be done every time residents have an appointment. R #41 was complaint with treatment. If she misses, it throws her off. LPN #1 further stated that this communication was important to know the status of the residents when they go to dialysis and when they come back in case there are any issues. F. On 06/27/24 at 12:13 pm during interview with Medical Records (MR) clerk, she stated she was looking for the missing forms. She was unable to provide any documents at this time. G. On 07/01/24 at 11:20 am during interview with Director of Nursing (DON), she stated the residents should have a dialysis communication form each time they go to dialysis, the reason for the communication form is so the facility and the dialysis center will know what issues the resident may currently have or if any labs need to be ordered.

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	07/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review, observations and interviews the facility failed to ensure the facility had sufficient staff to meet the needs of all 109 residents residing in the facility when staff failed to: 1. Offer baths or showers to residents as scheduled; 2. Supervise residents during residents smoking times. These deficient practices are likely to negatively impact resident safety, comfort, and to impede processes such as timely incontinence care (assisting residents to the bathroom or changing adult briefs), regular turning schedules (moving or turning residents that need assistance and are unable to move on their own), showers, and appropriate assistance with meals. The findings are: Baths/Showers: A. Record review of R #41's face sheet revealed R #41 was admitted into the facility on [DATE]. B. Record review of R #41's care plan dated 05/07/24 revealed, Focus: [Name of R #41] requires assistance with ADL care/ transfers and mobility r/t [related to] dx [diagnosis] of seizures/ epilepsy/ ESRD [end stage renal disease]/ Hemiplegia [paralysis of one side of the body] R [right]/ Weakness, dialysis, liver cirrhosis, HTN [hypertension- high blood pressure] and generalized weakness. Interventions: One staff assist with showers per schedule and prn [as needed]. She requires physical assistance with bathing. C. Record review of the facility shower schedule revealed R #41 was to be offered/given a bath/shower every Tuesdays, Thursdays, and Saturdays. D. Record review of R #41's documentation survey report (ADL tracking form on electronic health record-EHR) dated 05/01/24 through 05/31/24 revealed R #41 was offered/given 4 baths/showers out of 13 opportunities. E. Record review of R #41's shower sheets dated 05/01/24 through 05/31/24 revealed R #41 was offered/given 2 baths/showers out of 13 opportunities. F. Record review of R #41's documentation survey report dated 06/01/24 through 06/30/24 revealed R #41 was offered/given a bath/shower for 3 out of 10 opportunities. G. Record review of R #41's shower sheets dated 06/01/24 through 06/30/24 revealed R #41 was offered/given 6 baths/showers out of 10 opportunities. (continued on next page)

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	07/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H. On 06/24/24 at 3:01 pm during an interview with R #41, she had disheveled hair. R #41 stated that she was supposed to be offered and/or receive three baths/showers a week on Tuesdays, Thursdays, and Saturdays. R #41 also stated that she frequently is not offered and/or given a shower due to staff saying they are busy. R #41 confirmed she recently has gone multiple days without a shower and she does not feel good when she is not offered and/or given a bath/shower. I. On 06/30/24 at 2:47 pm during an interview with Certified Nursing Assistant (CNA) #1, R #41 should be offered/given at least three baths/showers per week. J. On 07/03/24 at 1:46 pm during an interview with Director of Nursing (DON), she stated that R #41 should be offered at least three baths/showers a week and R #41 was not offered. DON also confirmed staff should document any bath/shower refusals. K. Record review of R #50's face sheet revealed R #50 was admitted into the facility on [DATE]. L. Record review of R #41's care plan dated 01/18/24 revealed, Focus: [Name of R #50] requires assistance/is dependant for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to weakness, impaired mobility [.] Interventions: Max assist with showers and alert nurse if nails need to be trimmed since she is diabetic. M. Record review of the facility shower sheet revealed R #50 was to be offered/given a bath/shower on Thursdays and Sundays. N. Record review of R #50's documentation survey report dated 05/01/24 through 05/31/24 revealed R #50 was offered/given a bath/shower for 4 out of 9 opportunities. O. Record review of R #50's shower sheets dated 05/01/24 through 05/31/24 revealed R #50 was offered/given a bath/shower for 1 out of 9 opportunities. P. Record review of R #50's documentation survey report dated 06/01/24 through 06/30/24 revealed R #50 was offered/given a bath/shower for 2 out of 9 opportunities. Q. Record review of R #50's shower sheets dated 06/01/24 through 06/30/24 revealed R #50 was offered/given a bath/shower for 4 out of 9 opportunities. R. On 06/24/24 at 12:00 pm during an interview with R #50, she stated that most of the time she will only receive one shower a week due to staffing. R #50 confirmed she wanted at least two showers a week and she doe not feel good when she is only offered one. S. On 06/30/24 at 2:44 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated R #50 should be offered at least two baths/showers a week and CNAs should document resident baths/showers in the EHR and on shower sheets. T. On 06/30/24 at 2:53 pm during an interview with CNA #1, he stated R #50 has missed showers due to staffing. CNA #1 also stated R #50 approached him this morning to complain about her lack of showers and R #50 told him she felt gross and dirty. (continued on next page)

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	07/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	U. On 07/03/24 at 1:42 pm during an interview with the DON, she stated her expectation is baths/showers are completed and staffing should not be an issue for that. DON confirmed R #50 was not offered enough baths/showers and should have been. V. Record review of R #69's face sheet revealed R #69 was admitted into the facility on [DATE]. W. Record review of R #69's care plan dated 06/11/24 revealed, Focus: [Name of R #69] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Recent fall, Weakness, low back pain, hospitalization , dehydration and failure to thrive [.] Interventions: Help with showers of one staff, ensure his nails are cleaned and he is shaved. X. Record review of the facility shower schedule revealed R #69 was yo be offered/given a bath/shower on Thursdays and Saturdays. Y. Record review of R #69's documentation survey report dated 05/01/24 through 05/31/24 revealed R #69 was offered/given a bath/shower for 4 out of 9 opportunities. Z. Record review of R #69's shower sheets dated 05/01/24 through 05/31/24 revealed R #69 was offered/given a bath/shower for 1 out of 9 opportunities. AA. Record review of R #69's documentation survey report dated 06/01/24 through 06/30/24 revealed R #69 was offered/given a bath/shower for 3 out of 9 opportunities. BB. Record review of R #69's shower sheets dated 06/01/24 through 06/30/24 revealed R #69 was offered/given a bath/shower for 7 out of 9 opportunities. CC. On 06/23/24 at 3:39 pm during an interview with R #69, he stated that he is not offered/given baths/showers at least two times a week and he would like that. DD. On 07/03/24 at 1:43 pm during an interview with the DON, she confirmed R #69 was not offered/given enough baths/showers and should have been. Resident Smoking: EE. Record review of R #63's face sheet revealed R #63 was admitted into the facility on [DATE]. FF. Record review of R #63's smoking evaluation dated 12/27/23 revealed R #63 required supervision while smoking. GG. Record review of R #63's care plan dated 07/01/24 revealed, Focus: [Name of R #63] may smoke with supervision per smoking assessment. He has been out in courtyard several times smoking unsupervised. Management has addressed the rules with him and he needs close supervision. Ensue he is smoking tobacco only and not Marijuana. Interventions: Inform of and reinforce smoking restriction, Inform family and significant others that the patient needs supervision while smoking, Reassess patients ability to smoke with supervision with any change in condition, Supervise patient with smoking in accordance with assessed needs. (continued on next page)

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	07/16/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	HH. On 06/24/24 at 10:34 am during an smoking observation, R #63 smoked in the courtyard with other residents, staff was not present. II. On 06/30/24 at 2:44 pm during an interview with LPN #1, she stated R #63 requires supervision when smoking and staff should be out in the courtyard during all smoking times. LPN #1 also stated it's difficult for staff to go outside during smoking times due to staffing. JJ. On 07/03/24 at 1:52 pm during an interview with the DON, she stated CNAs and other staff should be supervising residents smoking during smoking hours. KK. Record review of R #68's face sheet revealed R #68 was admitted into the facility on [DATE]. LL. Record review of R #68's smoking evaluation dated 02/19/24 revealed R #68 could smoke independently. MM. Record review of R #68's care plan dated 06/21/24 revealed, Focus: [Name of R #68] may smoke with supervision per smoking assessment. Interventions: Ensure that appropriate cigarette disposal receptacles are available in smoking areas, Lighters or matches must be maintained by center staff; e-cig charging must occur at nurses' station, Monitor compliance with smoking policy, smoking assessments ongoing per policy, supervise patient while smoking for safety. NN. On 06/23/24 at 2:38 pm during an smoking observation, R #68 smoked in the courtyard without staff present.

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	07/16/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure for 1 (R #55) of 1 (R #55) resident reviewed for behavioral health concerns received necessary behavioral health care to meet their needs by staff not: 1. Ensure R #68's behavioral health/psychiatric (psych) progress notes were documented for facility staff in R #68's Electronic Health Record (EHR). 2. Referred R #70 to a psych services provider per physician orders. These deficient practices are likely to result in the residents not receiving the behavioral or mental health care and assistance needed to improve mood and reduce depression and anxiety. The findings are: R #68: A. Record review of R #68's face sheet revealed R #68 was admitted into the facility on [DATE]. B. Record review of R #68's physician orders dated 09/15/22 revealed, Please refer to [Name of Psych Services Provider] for psychiatric eval [evaluation] and treatment. C. Record review of R #68's care plan dated 06/21/24 revealed, Focus: [Name of R #68] exhibits or is at risk for distressed/fluctuating mood symptoms related to: Psychiatric Disorder. Interventions: Refer to Behavioral Health Specialist as needed. D. Record review of R #68's psychiatric progress notes dated 03/07/24 revealed R #68 was seen by the psych provider that day (03/07/24) and was scheduled for a follow-up appointment in one to three months, or as needed. E. Record review of R #68's EHR, revealed the record did not contain any other psych provider progress notes for R #68, even though R #68 had been seen by a psych provider since 03/07/24. F. On 06/30/24 at 2:44 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated that R #68's updated psych provider documentation should be present in R #68's EHR. LPN #1 confirmed the latest psych provider documentation in R #68's EHR was on 03/07/24, but she believed R #68 was seen by a psych provider more recent than that. G. On 07/02/24 at 3:29 pm during an interview with the psych provider Human Resources Director (HRD), she stated that R #68 was seen by the psych provider on 05/28/24 and 06/29/24, and the psych provider had R #68's psych provider notes for R #68's most recent psych provider session to provide to the facility. HRD confirmed she had tried to send R #68's psych provider notes to the facility multiple times but the facility had not taken initiative to set up a way to receive R #68's psych provider notes for R #68's EHR, even after the HRD had contacted the facility multiple times about this issue. (continued on next page)

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	07/16/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 07/03/24 at 1:40 pm during an interview with the Director of Nursing (DON), she stated R #68's latest psych provider notes should be in his EHR for staff to review. DON confirmed R #68's psych provider notes were not up to date in R #68's EHR. R #70: I. Record review of R #70's face sheet revealed R #70 was admitted into the facility on [DATE] with the following diagnoses: 1. Anxiety. 2. Depression. J. Record review of R #68's care plan dated 04/16/24 revealed, Focus: Resident/Patient exhibits psychosocial distress with own well-being and/or social relationships related to: Frequent conflict with personal relationships with family/significant other, friends, other residents, and/or staff. Interventions: Evaluate need for Psych/Behavioral Health consult. K. Record review of R #70's physician orders dated 04/24/24 revealed, Psych referral for talk treatment therapy. L. On 06/25/24 at 9:30 am during an interview with R #70, he stated that he was depressed because he was broke and did not have any possessions. R #70 confirmed he has not spoken to a psych provider and he would like to. M. On 07/02/24 at 3:34 pm during an interview with the psych provider HRD, she stated they have not received a psych referral from the facility for R #70. HRD confirmed the facility has not reached out to the psych provider regarding R #70. N. On 07/02/24 at 4:23 pm during an interview with the Social Services Director (SSD), she stated she sent a psych referral for R #70 to the psych services provider on 04/26/24 via their website. SSD confirmed she never followed up with R #70's psych service referral and she never contacted the psych services provider regarding R #70. O. On 07/03/24 at 1:47 pm during an interview with the DON, she stated R #70 should have had a psych referral sent per physician orders and the facility SSD should have followed-up with R #70's psych referral.

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	07/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 39509 Based on record review and interview, the facility failed to ensure that the consultant pharmacist recommendations were reviewed and considered each month for 1 (R #97) of 5 (R # 12, 39, 45, 66, and 97) residents reviewed for medication regimen. If consultant pharmacist's recommendations are not reviewed by the facility and health care provider monthly, residents are likely to experience unnecessary drug interactions and adverse side effects. The findings are: A. Record review of R #97 face sheet dated 06/30/24 revealed R #97 was admitted to facility on 02/17/24 with multiple diagnoses including: -Alcoholic Cirrhosis of Liver (damage of the liver due to past alcohol intake) -Alcohol Dependence (a perceived need to consume alcohol) with Alcohol Induced Disorder (unspecified disorder that is caused by past or present use of alcohol) -Anxiety Disorder (unusual nervousness) -Repeated Falls B. Record review of R #97's pharmacist consultation report dated April 1, 2024 to April 23, 2024 revealed a recommendation by the consulting pharmacist to monitor R #97 for involuntary movements now and for at least six months due to use of Risperidone (a medication that treats various psychiatric conditions) which may cause involuntary movements. The recommendation did not indicate that it had been reviewed and accepted or rejected by the facility or provider. C. Record review of R #97's physician orders dated 04/15/24 revealed a physician order to administer Risperidone 1 mg (milligram), give 2 tablets by mouth two times a day for anxiety. The physician orders did not include any order to monitor R #97 for any related side effects or movements that may have been caused by the medication. D. Record review of R #97's pharmacist consultation reported dated May 1, 2024 to May 15, 2024 revealed a recommendation by the consulting pharmacist to attempt a gradual dose reduction (a small reduction in a medication completed gradually over a period of time to attempt to reduce the overall medication dose) of Hydroxyzine (a psychotropic medication prescribed to reduce anxiety) 50 mg. The recommendation did not indicate that it had been reviewed and accepted or rejected by the facility or provider. E. Record review of R #97's physician orders dated 03/07/24 revealed a physician order to administer 50 mg hydroxyzine three times a day for anxiety. There is no physician order to monitor or reduce the dosage of the medication. (continued on next page)

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	07/16/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 06/30/24 at 3:30 pm during interview with Director of Nursing, she reviewed R #97's medical record and pharmacist's consulting reports. DON stated that she was not employed with the facility in April or May 2024. She could not confirm that either pharmacy recommendation had been reviewed, considered, rejected or ordered.

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	07/16/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 39509 Based on record review and interview, the facility failed to ensure that 1 (R #97) of 5 (R #12, 39, 45, 66, and 97) resident's prescription for a PRN (as needed) psychotropic medication was reviewed and renewed every 14 days by the prescriber. This deficient practice is likely to result in residents receiving medications without regular review or oversight causing over-sedation and other negative side effects. The findings are: A. Record review of R #97 face sheet dated 06/30/24 revealed R #97 was admitted to facility on 02/17/24 with multiple diagnoses including: -Alcoholic Cirrhosis of Liver (damage of the liver due to past alcohol intake) -Alcohol Dependence (a perceived need to consume alcohol) with Alcohol Induced Disorder (unspecified disorder that is caused by past or present use of alcohol) -Anxiety Disorder (unusual nervousness) -Repeated Falls B. Record review of R #97's physician orders dated 03/24/24 revealed an order to administer Lorazepam (a anti-anxiety psychotropic medication) 2 MG (milligram) give 1 tablet by mouth every 5 hours as needed for increased anxiety with manic episodes (episodes of fear and anxiety). C. Record review of R #97's Medication Administration Record (MAR) revealed the following: -March 2024 Lorazepam 2 mg was administered on 03/27, 03/28 and 03/29. -April 2024 Lorazepam 2 mg was not administered during the month. -May 2024 Lorazepam 2 mg was not administered during the month. -June 2024 Lorazepam 2 mg was administered on 06/26. D. On 06/30/24 at 4:11 pm during interview with Director of Nursing (DON), she confirmed that R #97 had a standing order to administer Lorazepam 2 mg PRN. She confirmed that this order should have been reviewed and renewed every two weeks-DON confirmed the order had not been reviewed as required.

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	07/16/2024

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 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. 34439 Based on observation and interview the facility failed to: 1. Ensure all medications were stored properly and in the original, labeled packaging. 2. Ensure medical supplies in the medication carts were not expired. 3. Ensure medication carts were locked when unattended. 4. Ensure medications were labeled with open date These deficient practices are likely to negatively impact the health of all residents, if staff administered or used potentially compromised or contaminated medications. The findings are: Findings for loose medications: A. On 06/23/24 at 12:15 PM during observation of the medication cart, two unidentified loose pills were on the bottom of the second drawer of the cart. B. On 06/23/24 at 12:16 PM during interview Licensed Practical Nurse (LPN) #3 confirmed that there were two loose unidentified pill in the drawer of the cart and they should not be there and should be destroyed. Findings for expired medical supplies in the Medication Cart: C. On 06/26/24 at 8:57 PM during observation of the medication cart revealed a bag with approximately ten 16 mm (millimeter-unit of measurement) syringes were in the top drawer of the cart and had an expiration date of 07/21/23. D. On 06/26/24 at 9:02 PM during an interview with LPN #4, she confirmed that the expired syringes in the medication cart should not be in there and should have been removed from the cart. Findings for unlocked Medication Carts: E. On 06/23/24 at 12:12 PM during an observation of the south side medication cart, the cart was unlocked and staff left the cart unattended. F. On 06/23/24 at 12:13 PM during interview with LPN #5, she confirmed that medication carts should not be left unlocked and unattended. G. On 06/23/24 at 12:15 PM during observation of North Side medication cart, the cart was unlocked and staff left the cart unattended. (continued on next page)

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	07/16/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 06/23/24 at 12:20 PM during an interview, LPN #3 stated the North Side medication cart does not lock all the time, that is why it is left unlocked and unattended when I am busy assisting residents. I. On 06/26/24 at 8:57 PM during observation of the north side medication cart, the cart was unlocked and unattended. J. On 06/26/24 at 9:02 PM during an interview, LPN #4 stated, medication carts should be locked at all times when they are unattended, and the cart was not locked. K. On 06/26/24 at 9:08 PM during observation of the south side medication cart, the cart was unattended and unlocked. L. On 06/26/24 at 9:10 PM during an interview, Registered Nurse (RN) #1 confirmed that medication cart was unlocked and should not be unlocked and unattended. M. On 06/29/24 at 11:21 AM during observation south side medication cart, the cart was unlocked. N. On 06/29/24 at 11:24 during an interview, LPN # 3 confirmed that medication cart should not be left unattended and unlocked. O. On 06/30/24 at 7:50 AM during observation of the south side medication cart, the cart was left unlocked and unattended. P. On 06/30/24 at 7:57 AM during an interview, LPN #6 confirmed the medication carts should not be left unattended and unlocked. Findings for open medication with no open date: Q. On 06/26/24 at 8:57 PM during observation of the medication cart there were Insulin pens for R #113, R #117, R #106, R #4 and R #77 all Insulin pens were not labeled with an open date. R. On 06/26/24 at 9:08 PM during an interview, RN #1 verified that all residents insulin pens should be labeled with an open date. S. On 07/01/24 at 11:20 AM during an interview with the Director of Nursing (DON), she stated that medication carts are to be locked at all times when not in use. All expired medications and loose pills should be discarded. She further stated that all insulin pens should be labeled and dated with open date because insulin pens do have a shelf life.

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	07/16/2024

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on observation, record review and interview, the facility failed to ensure dental services were obtained for 1 (R #114) of 1 (R #114) residents reviewed for dental care and services. This deficient practice could likely result in the residents not receiving dental care and services to meet their needs. The findings are: A. On 06/25/24 at 10:37 AM during an observation and interview with R #114, R #114's lower dentures were not in his mouth at the time of interview. R #114 stated that his bottom denture has been missing for a couple months, (unsure of the exact dater) He further stated that he and his brother had reported it missing and nothing has been done. B. Record review of R #114's care plan dated 6/27/24 revealed R #114 is at risk for oral health or dental care problems as evidenced by missing teeth and resident has a hard time keeping track of dentures. Resident has upper and lower dentures, but does not always wear them. C. On 06/28/24 at 11:27 AM during interview with Social Services Director (SSD) she stated she was aware that R #114 was missing his bottom dentures and the facility has not been replaced the bottom dentures. The bottom dentures went missing the day of or the day before this last hospitalization on [DATE]. D. On 07/01/24 at 11:41 AM during an interview with the Director of Nursing (DON), she stated the facility should have known about the missing denture. The facility is responsible for identifying lost or broken dentures and should replace them as quickly as possible. E. On 07/03/24 at 9:00 AM during an interview with R #114's brother he stated that his brother had gone two months without his lower denture and he had to bring it to the facility's attention that the dentures were missing again. This notification was on 06/09/2024. R #114's brother further stated that this was the second time his denture were lost. The first time the dentures were lost he paid for them to be replaced but this is the second time within a year and he feels that the facility should be responsible.

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	07/16/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interviews, the facility failed to ensure residents obtained routine dental care for 1 (R #50) of 1 (R #50) resident reviewed for dental services. This failure is likely to result in the resident experiencing pain, embarrassment over condition of teeth, and potential weight loss. The findings are: A. Record review of R #50's face sheet revealed R #50 was admitted into the facility on [DATE]. B. Record review of R #50's nursing progress notes dated 02/26/24 revealed R #50 had a dental appointment scheduled on 03/07/24 at 8:15 am. C. Record review of R #50's care plan dated 02/29/24 revealed R #50 was edentulous (lacking teeth) and staff were to assist R #50 with brushing and cleaning R #50's dentures and monitor for change in fitting of dentures. D. On 06/24/24 at 12:13 pm during an observation and interview with R #50, R #50 did not have dentures present. R #50 stated her dentures do not fit and she needed another dentist appointment because she could not attend her dental appointment on 03/07/24 due to her requiring facility staff assistance getting out of her wheelchair and into the dentist chair. R #50 confirmed she asked for another dental appointment but she was told by the facility that there was not enough staff available to take her. E. On 07/01/24 during an interview with the facility Receptionist (REC), she stated that she is responsible for making resident appointments and and ensuring residents have transports to those appointments with staff as needed. REC stated that R #50 did not make it to her dental-dentures appointment on 03/07/24 because R #50 required staff assistance and due to short staffing, the facility could not accommodate R #50's transfer needs. REC confirmed R #50's dental-dentures appointment was never rescheduled and R #50 has not had a dental appointment since that missed one on 03/07/24. F. On 07/01/24 at 11:41 am during an interview with the Director of Nursing (DON) she stated the facility should have accommodated R #50 with staff assistance for a dental appointment. DON confirmed R #50 has not had a dental appointment scheduled since the missed appointment on 03/07/24 and R #50 should have had one.

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	07/16/2024

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 47031 Based on record review and interview, the facility failed to ensure staff provided residents with a nourishing bedtime snack to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day for 6 (R #21, R #53, R #36, R #20, R #99, and R #97) of 6 (R #21, R #53, R #36, R #20, R #99, R #97) residents reviewed for snacks. This deficient practice could likely cause frustration and lead to unnecessary hunger. The findings are: A. Record review of Meal Times, no date, revealed staff served dinner at 5:00 PM and breakfast at 7:30 AM (14.5 hours between meal services.) All meals are served at the same time, hall trays will go out and then they will serve any residents that are seated in the dining room. B. On 06/24/24 at 3:11 PM, during an interview with the Resident Council, R #21, R #53, R #36, R #20, R #99, and R #97 stated they were not provided with a snack at bedtime and dinner was served at 5:00 PM. Residents stated that they would like to have snacks at bedtime because it is a long night and some residents get hungry. Snacks used to be provided at night in the past but are no longer available and they would like them (snacks) brought back. C. On 06/25/24 at 12:04 PM, during an interview, the Dietary Manager revealed staff did not hand out snacks to residents individually. He stated staff leave snacks in the nourishment room for those residents who asked for a snack. DM stated he did not know if nursing staff let residents know snacks were available.

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	07/16/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47031 Based on observation, interview, and record review, the facility failed to: 1. Ensure unknown food storage containers were labeled and stored appropriately. 2. Ensure a garbage bin was covered and away from ready to eat foods on the food preparation area. 3. Ensure one gallon plastic jug of salsa open to air. 4. Ensure a tray of what appeared to be cake was not labeled or dated. 5. Ensure Dietary Aide serving lunch line was wearing a hair restraint. 6. Ensure one can of chili con carne was not stored on bare floor in dry storage area. 7. Ensure back door of the kitchen area was not propped opened These deficient practices are likely lead to foodborne illnesses and have the potential to affect all 109 residents who eat food prepared in the kitchen identified on the census list provided by the Administrator on 06/23/2024. The findings are: A. On 06/23/24 at 11:30 am, during an observation of the kitchen, the following was reveavled: 1. Storage containers in the refrigerator with unidentified food were not appropriately stored or dated. 2. A large garbage bin was next to the food preparation table. The garbage bin was uncovered and had food and liquid inside. 3. An open one gallon plastic jug of salsa was left open to air in the walk-in refrigerator 4. A tray of what appears to be some type of cake was unlabeled and undated in the walk-in refrigerator. 5. Dietary aide served lunch and did not wear a hairnet restraint nor was hair restrained. 6. One can of chili con carne (chili with meat) was stored on bare floor in the dry storage room 7. Dietary back door was propped open to dock. B. On 06/23/24 at 11:48 am, during an interview with [NAME] #1, he stated the chili con carne can should not be stored on the bare floor. He also stated the storage containers in the refrigerator with unidentified food were not appropriately stored or dated. (continued on next page)

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	07/16/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. On 06/23/24 at 11:58 am during an interview with the Dietary Manager, he stated it was not appropriate to have the dietary doors propped open. The DM stated the doors should be closed at all times. DM further stated that trash cans should not be un-covered when in the food prep area.

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	07/16/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47091 Based on observation and interview, the facility failed to adequately maintain and implement an infection prevention and control program for all residents by: 1. Not covering laundry carts when in hallway when delivering resident laundry. 2. Staff placing personal protective equipment (respiratory equipment, garments, and barrier materials used to protect rescuers and medical personnel from exposure to biological, chemical, and radioactive hazards.) (PPE) in resident trash cans without liners and resident's room did not have PPE bins resident's room to doff (remove) PPE. These deficient practices are likely to affect all 109 residents in the facility as identified on the census list provided by the Assistant Director of Nursing on 06/22/24. Failure to follow and implement an infection control program is likely to cause the spread of infections and illness to residents and staff within the facility. The findings are: A. On 06/24/24 at 10:57 am during random observation of a housekeeper #1 pushed a rolling rack of clothing down the hallway. A bed sheet laid on the top of the rolling rack and the rack was only covered on the top part of the rack leaving the bottom of the rack which contained clean clothing uncovered. B. On 06/24/24 at 10:57 am during an interview, housekeeper #1 stated the clothing rack she was pushing down the hallway needed to be covered and the clothing rack was not covered. C. On 07/02/24 during observation of resident rooms 101, 105 and 116 trash cans in the rooms were filled with used PPE and did not have trash liners . The following rooms 101, 105 and 116 did not have any PPE bins for staff to doff PPE. D. On 06/23/24 at 3:22 pm during interview with Director of Nursing, she confirmed that all rooms should have PPE bins and all trash cans should have liners. E. On 07/02/24 at 5:25 pm during interview/walk through with Infection Preventionist (IP), she confirmed that PPE was discarded in resident trash bins in rooms 101, 105, 113 and 116 and did not have trash liners. She stated it was her understanding that resident trash bins could be used to discard PPE. She confirmed that there was no trash bin in room # 127 and that there should be a trash bin.

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	07/16/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 34439 Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for all 109 residents by: 1. Not emptying trash bins on a regular basis and allowing them to overflow. 2. Not replacing a broken washer machine and having only one washer which was leaking in laundry room. 3. Leaving cigarette butts on the ground and allowing other residents to pick them up. These deficient practices could likely effect all 109 residents in the facility as identified on the census list provided by the Assistant Director of Nursing on 06/22/24. Failure to have a sanitary facility is likely to cause the spread of infections and illness to residents and staff within the facility. The findings are: A. On 06/23/24 at 2:59 pm during observation of facility grounds revealed the following: 1. Three large trash bins were in the back of the facility, the trash bins were uncovered and overflowing with their contents falling onto the ground around them. 2. One extra large trash bin was uncovered and filled to capacity, with four mattresses sitting on the ground beside the extra large trash bin. 3. Cigarette butts were left on the facility patio area B. On 06/23/24 at 3:22 pm during interview with Director of Nursing, she confirmed that the trash bins outside were overflowing and should not be. She further stated the trash bins should be emptied twice a week. C. On 06/23/24 at 12:00 pm during observation of facility grounds a resident picked up cigarette butts and put the cigarette butts in his mouth. D. On 06/24/24 at 11:17 am during walk through of the facility laundry room, the washing machine leaked from the bottom and sat in a puddle of standing dirty water. The other washing machine was broken and had since been removed from the facility and had not been replaced. E. On 06/24/24 at 11:17 am during walk through of laundry room housekeeper #1 stated the facility should have two washing machines, she further stated one machine is broken and the other washing machine was leaking and standing on dirty water on the floor. She also stated she is not sure when they will be replace the washing machine and it is also unsanitary to have standing water in the laundry room.

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	07/16/2024

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41988 Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of no less than 12 hours per year for 2 (CNAs #7 and #8) of 5 (CNAs #7, #8, #9, #10, and #11) CNAs randomly reviewed for required in-service training. This deficient practice is likely to result in the nurses aides not receiving the necessary training to meet the care needs of the residents. The findings are: CNA #7: A. Record review of the facility staffing list revealed CNA #7 was hired on 10/01/18. B. Record review of CNA #7's facility in-services and training's dated 10/01/22 through 10/01/23 revealed CNA #7 had only completed 8 hours out of the 12 required hours of training. C. Record review of the facility staffing schedule dated 07/01/24 through 07/03/24 revealed CNA #7 had worked three out of three shifts. D. On 07/03/24 at 4:30 pm during an interview with the Director of Nursing (DON), she confirmed CNA #7 had only 8 hours of training completed and was out of compliance. DON stated CNA #7 should not have been working the floors without the required 12 hours of training. CNA #8: E. Record review of the facility staffing list revealed CNA #8 was hired on 04/19/22. F. Record review of CNA #8's facility in-services and training's dated 04/19/23 through 04/19/24 revealed CNA #8 had only completed 11.5 hours out of the 12 required hours of training. G. Record review of the facility staffing schedule dated 07/01/24 through 07/03/24 revealed CNA #8 had worked three out of three shifts. H. On 07/03/24 at 4:31 pm during an interview with the DON, she confirmed CNA #8 had only 11.5 hours of training completed and was out of compliance. DON stated CNA #8 should not have been working the floors without the required 12 hours of training.