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	07/21/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to notify the physician when a change in cognitive status (an individual's level of awareness with perception, reasoning, judgment, intuition, and memory) was observed for 1 (R #10) of 3 (R #10, R #11, and R #12) residents reviewed for change in condition. The delay in treatment likely resulted in R #10 experiencing a stroke [CVA (a type of Cerebrovascular Accident, or stroke, which results in the loss of blood flow, nutrients, and oxygen to multiple regions of the brain, resulting in neuronal damage and subsequent neurological deficits). The findings are: A. Record review of R #10's EHR (Electronic Health Record) revealed that he was admitted on [DATE] with the following pertinent diagnosis unspecified atrial fibrillation (abnormal beating of the heart), heart failure (when the heart is unable to pump blood as it normally should), COPD (Chronic Obstructive Pulmonary Disease- continuous lack of airflow in the lungs), history of ischemic attack (lack of blood flow to certain parts of the brain, resulting on a lack of oxygen), essential hypertension (abnormally high blood pressure that is not caused or related to a medical condition), and sleep apnea (a conditional where breathing repeatedly stops and resumes while sleeping). B. Record review of the Radiology Physician's Order, date unspecified, revealed .please stop his Eliquis [brand name of an anticoagulant medication, also known as Apixaban] 5 days prior to his angiogram on May 11. Elequis can be re-started on May 12. C. Record review of Physician's Order, dated 02/01/22, revealed that R #10 was ordered to receive Apixaban [an anticoagulant medication] Tablet 2.5 MG (Milligram), Give 1 tablet by mouth two times a day for A.Fibb [atrial fibrillation]. Further review of physician's orders revealed 2 additional orders related to Apaxiban: Dated 05/03/22, Apixaban Tablet 2.5 MG Give 1 tablet by mouth two times a day for A.Fib until 05/06/2022 23: 59 STOP 5 DAYS BEFORE ANGIOGRAM MAY 11 2022. Dated 05/04/22, Apixaban Tablet 2.5 MG Give 1 tablet by mouth two times a day for A.Fib until 05/06/2022 23: 59 STOP 5 DAYS BEFORE ANGIOGRAM MAY 11 2022. D. Record review of the Medication Administration Record (MAR) revealed that 05/06/22 was the last day he received Apaxiban as it was not re-started on 05/12/22. Further review of MAR revealed that no additional anticoagulants were prescribed. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	E. On 07/20/22 at 1:15 pm, during an interview with the Center Nurse Executive (CNE), she confirmed that the medication was only to remain on hold until 05/11/22 and then resume on 05/12/22. F. Record review of nursing notes by RN (Registered Nurse) #1, dated 05/22/22, revealed Resident had some changes in cognition since Friday [05/20/22] progressively getting incoherent by the day. Unable to Follow Simple Commands. Spontaneous Eye Opening Confused on Verbal response Moves to Localize Pain E4V4M5 [a stroke scoring assessment where each ability to move upper and lower limbs, is a number between 0 and 4, 0 being normal functioning and 4 being completely impaired]. Sent to ER (emergency room) for further Evaluation. G. On 7/21/22 at 12:16 pm, during an interview with the Staffing Coordinator, when asked to confirm who worked with R #10 on 05/19/22, 05/20/22, and 05/21/22, she explained that LPN #2 worked 05/19/22, RN #3 worked on 05/20/22 and 05/21/22. H. On 07/21/22 at 12:02 pm, during an interview with RN #1, when asked to explain R #10 at his baseline [regular day-to-day function], he explained He is very particular about how we help him. When asked to recall R #10 prior to his discharge to the hospital, he explained that upon starting his shift, he immediately saw that R #10 needed to go to the hospital. He then stated, When I was there, right before he was hospitalized , he was not answering questions appropriately. He wasn't making any sense. He used to know a lot about his meds [medications] but [before going to the hospital] he didn't know anything. When asked if the physician was notified of this change, he replied, Usually, the doctor is notified on what is going on. When I sent him out [to the ER] the physician was notified. RN #1 confirmed that he did not notify the physician of R #10's change in condition prior to 05/22/22. He stated I only work there 3 days a week. The day I sent him to the hospital [05/22/22], that was my first day for the week. When asked how he was aware that he was progressively getting incoherent by the day he replied, The nurse [that he was relieving] let me know during report [a reporting process where one shift will communicate with the oncoming shift] and when I did my assessments, I noticed the change. The nurse told me that he was different. I. On 07/21/22 at 12:35 pm, during an interview with RN #3, when asked to recall R #10 prior to his ER visit, he stated He was incoherent and confused. When asked how he became aware of his (R #10) confusion, he stated The nurse [from the previous shift] let me know of his changes. J. On 07/19/22 at 9:39 am, during an interview, R #10's family member explained that R #10 was scheduled for an appointment to receive an angiogram (a scan that shows the blood flow through veins or arteries) on 05/11/22. To perform this scan, the performing physician ordered R #10's anticoagulant (medication that prevents the blood form clotting) to hold for 5 days prior to the appointment. She then explained that R #10 did not attend the angiogram appointment due to transportation issues and the that the anticoagulant medication did not resume as ordered. Later in his stay, he was sent to the hospital due a stroke. K. Record review of hospital documentation, dated 07/04/22, revealed that R #10 was in the hospital for 42 days and 18 hours where he presents with confusion and expressive asphasia . Found to have acute multifocal CVA. I. On 7/20/22 at 11:05 during interview with CNA (Certified Nurse Aide) #2, she confirmed that after the stroke R #10 now requires hoyer lift (assistive device that assist in transfers between a bed and a chair or other similar resting places) with total support for transfers.

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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** 35632 Based on observation, interview, and record review the facility failed to provide ADL (Activities of Daily Living; fundamental skills required to care for oneself such as eating, bathing & mobility) assistance according to residents needs for 5 (R #2, 3, 4, 14, and 15) of 5 (R #2, 3, 4, 14, and 15) residents reviewed for Activities of Daily Living. This deficient practice could likely affect the dignity and health of the residents. The findings are: A. Record review of the grievances indicated that a grievance was filed on 04/27/22, Indicated that for R #4 Resident would like to be offered to get up more often and to be repositioned more frequently. B. On 07/19/22 at 2:40 pm during an observation was made of R #4's room. A note was on the wall behind the bed and indicated to try to get resident out of bed every day between 2 to 2:30 pm. Observation made of the time being 2:40 pm. C. Record review of the grievances indicated that a grievance was filed on 05/04/22 for R #15 indicated the following, .Resident stated staff is not getting him up, stated it's been 4 days since I've been up in my chair . D. Record review of the grievances indicated that on 05/11/22 for R #15 .request to be toileted and the staff tell him there is no lift available and has to wait. Resident stated sometimes fecal matter runs down his leg. E. Record review of the grievances indicated that a grievance was filed on 05/10/22 for R #14, the grievance indicated that name of resident (R #14) stated that day CNA (Certified Nurse Assistance) told her she was too busy to get her out of bed. She stated this CNA often tells her this .also stated that this CNA often makes her wait up to two hours to assist her to the bathroom stating she is too busy . Response to grievance indicated the following, Resident usually requests to get up during mealtime. This is a very busy time therapy is working with her so she can get up on her own and improve independence. F. On 07/19/22 at 10:30 am during an interview with R #14, she stated that she thinks the facility should be getting her up daily. She stated that it is a problem getting up because they don't have enough [NAME] lifts (a device that helps you to stand from a sitting position). R #14 stated that one time the lift was broken, and they couldn't get her up because of that. She likes to go to the bathroom when she needs to go, which means she needs the [NAME] lift for that and at times had waited up to two hours to go to the bathroom stating that they (staff) were too busy. R #14 stated that she filed a grievance on 04/29/22 for this issue. She stated that she is working with therapy so she can hopefully get out of bed on her own. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 07/19/22 at 2:40 pm during an interview with R #4, she stated that she never gets out of bed. She stated that she asked today to get up, but was not sure if that was going to happen. She requires a Hoyer lift (This is an assistive device that allows patients in hospitals and nursing homes and people receiving home health care to be transferred between a bed and a chair or other similar resting places) to get out of bed and sometimes she is told that they can't use it because the battery wasn't charged. Sometimes the Hoyer isn't available because it is being used for other residents. On 04/27/22 Grievance noted Resident would like to be offered to get up more often and to be repositioned more frequently. Resident was gotten up right away and will be helped up every day after lunch. There is an order for it and care plan was updated. H. On 07/19/22 at 3:05 pm, during an interview with Social Services Assistant, she stated that she was aware of some of the issues with the Hoyer lifts and getting residents out of bed. She stated that she is familiar with R #3 and that he wants to be up for a certain amount of time and then he wants to lay back down. She stated that when he gets up he wants to lay back down right away. It is an ongoing issue. I. On 07/20/22 at 9:35 am, during an interview with R #2, she stated that she had been in the facility for two years now. R #2 said that getting out of bed was her biggest challenge currently. She confirmed that she needs a Hoyer lift to get out of bed which requires two staff members to use. She doesn't think their is enough staff for that. J. On 07/20/22 at 9:50 am, during an interview with R #3, he stated that staff are not getting him up and it had currently been four days since he had last gotten up in his chair. He stated that he can't be out of bed for more than two hours at a time because that causes him a lot of pain. He wonders if that isn't part of the issue with staff getting him up. He requires a Hoyer lift to move from bed to chair and vice versa. K. On 07/20/22 at 11:42 am, during an interview with Unit Manager #1, he stated that the Hoyer/[NAME] lift issues are a problem. He stated that it was usually a timing issue for the residents and when they want to get up and be put back in bed. The staff have tried to work out a schedule with R #3. There had been times when he would have to wait until mealtime to be put back to bed. With R #14 and R #15 they had some toileting issues and for R #4 she can barely stand to be up in her chair for more then an hour. L. On 07/21/22 at 9:24 am, during an interview with Certified Nursing Assistant CNA #1 and Restorative Aide she stated that the Hoyer lift and [NAME] lift residents that want to get up in their chairs to eat in the dining room sometimes aren't able and will have to eat in their rooms because they don't have enough staff to accommodate everyone. She stated that a few of the Hoyer/[NAME] lift residents want to get up to go to the toilet for a few, but it takes two people for for the lifts and sometimes there isn't anyone to assist. She won't use the lifts alone. CNA #1 stated that R #14 was upset on Monday 07/18/22 because she didn't get up right away and R #14 told her that she didn't get up all weekend and didn't want to wait.

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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. 35632 Based on observation and interview the facility failed to ensure residents were free from accident hazards for all 22 residents residing in the memory care unit when they failed to ensure that residents were supervised when going outside. This deficient practices could likely result in residents being at risk of serious harm or death. The findings are: A. On 07/20/22 at 9:30 am, during an observation was made of several residents wandering up and down the halls on the secure memory care unit. the emergency door at the back of the hall was not closed all the way allowing residents to push the door open to go outside. B. On 07/20/22 at 9:40 am, during an observation was made of a resident going out the back door of the memory care unit. None of the staff appeared to be aware that the resident had gone outside. The resident was not asked to come back in and no one went outside to check on her. C. On 07/20/22 at 9:50 am, during an observation was made of Certified Nursing Assistant (CNA) #7, who was not working the memory care unit, but was asked to come back to assist with anything, saw the resident outside and immediately asked the resident to come in. The resident did come inside and initially CNA #7 couldn't get the door all the way closed. She tried again and got the door latched. D. On 07/20/22 at 9:51 am, during an interview with Certified Nursing Assistant #7, she stated that the door is supposed to be closed and the residents aren't supposed to be outside alone. E. On 07/20/22 at 9:52 am, Registered Nurse #4 stated that the residents are allowed to go out there. She stated that if the door wasn't cracked then the alarm would sound. When asked how they know who is going out she stated that they go out all of the time and that they know where everyone is. They also do a head count. F. On 07/20/22 at 11:30 am, during an interview with the Center Executive Director (CED) she stated that staff go outside with the residents who are on the memory care unit. She stated that staff need to watch the residents and if they are watching them it is fine to leave the door open. G. On 07/20/22 at 12:48 pm, during an interview with Center Nursing Executive (CNE) she stated that all the residents on the memory care unit need to be supervised when they are outside. It is not acceptable to have the door propped open so the residents can and go.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to follow Physician Orders for 1 (R #10) of 3 (R #10, R #11, and R #12) residents reviewed for medication administration. Failure to provide R #10 anticoagulant medication (blood thinner) for 10 days likely resulted in R #10 experiencing a stroke [CVA (a type of Cerebrovascular Accident, or stroke, which results in the loss of blood flow, nutrients, and oxygen to multiple regions of the brain, resulting in neuronal damage and subsequent neurological deficits)]. The findings are: A. Record review of R #10's EHR (Electronic Health Record) revealed that he was admitted on [DATE] with the following pertinent diagnosis unspecified atrial fibrillation (abnormal beating of the heart), heart failure (when the heart is unable to pump blood as it normally should), COPD (Chronic Obstructive Pulmonary Disease- continuous lack of airflow in the lungs), history of ischemic attack (lack of blood flow to certain parts of the brain, resulting on a lack of oxygen), essential hypertension (abnormally high blood pressure that is not caused or related to a medical condition), and sleep apnea (a conditional where breathing repeatedly stops and resumes while sleeping). B. Record review of the Radiology Physician's Order, date unspecified , revealed .please stop his Eliquis [brand name of an anticoagulant medication, also known as Apixaban] 5 days prior to his angiogram on May 11. Elequis can be re-started on May 12. C. Record review of Physician's Order, dated 02/01/22, revealed that R #10 was ordered to receive Apixaban [an anticoagulant medication] Tablet 2.5 MG (Milligram), Give 1 tablet by mouth two times a day for A.Fibb [atrial fibrillation]. Further review of physician's orders revealed 2 additional orders related to Apaxiban: Dated 05/03/22, Apixaban Tablet 2.5 MG Give 1 tablet by mouth two times a day for A.Fib until 05/06/2022 23: 59 STOP 5 DAYS BEFORE ANGIOGRAM MAY 11 2022. Dated 05/04/22, Apixaban Tablet 2.5 MG Give 1 tablet by mouth two times a day for A.Fib until 05/06/2022 23: 59 STOP 5 DAYS BEFORE ANGIOGRAM MAY 11 2022. D. Record review of the Medication Administration Record (MAR) revealed that 05/06/22 was the last day he received Apaxiban as it was not re-started on 05/12/22. Further review of MAR revealed that no additional anticoagulants were prescribed. E. On 07/20/22 at 1:15 pm, during an interview with the Center Nurse Executive (CNE), she confirmed that the medication was only to remain on hold until 05/11/22 and then resume on 05/12/22. F. Record review of nursing notes by RN (Registered Nurse) #1, dated 05/22/22, revealed Resident had some changes in cognition since Friday [05/20/22] progressively getting incoherent by the day. Unable to Follow Simple Commands. Spontaneous Eye Opening Confused on Verbal response Moves to Localize Pain E4V4M5 [a stroke scoring assessment where each ability to move upper and lower limbs, is a number between 0 and 4, 0 being normal functioning and 4 being completely impaired]. Sent to ER (emergency room) for further Evaluation. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	G. On 07/19/22 at 9:39 am, during an interview, R #10's family member explained that R #10 was scheduled for an appointment to receive an angiogram (a scan that shows the blood flow through veins or arteries) on 05/11/22. To perform this scan, the performing physician ordered R #10's anticoagulant (medication that prevents the blood form clotting) to hold for 5 days prior to the appointment. She then explained that R #10 did not attend the angiogram appointment due to transportation issues and the that the anticoagulant medication did not resume as ordered. Later in his stay, he was sent to the hospital due a stroke. H. Record review of hospital documentation, dated 07/04/22, revealed that R #10 was in the hospital for 42 days and 18 hours where he presents with confusion and expressive asphasia . Found to have acute multifocal CVA. I. On 7/20/22 at 11:05 during interview with CNA (Certified Nurse Aide) #2, she confirmed that after the stroke R #10 now requires hoyer lift (assistive device that assist in transfers between a bed and a chair or other similar resting places) with total support for transfers.