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	05/01/2023

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 - Immediate jeopardy to resident health or safety 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** 40795 Based on record review and interview, the facility failed to monitor wound for 1 (R #1) of 3 (R #'s 1, 2, and 3) residents reviewed for wound care of surgical sites by: 1. Not clarify medication and treatment orders from an outside provider and; 2. Not evaluating wound healing and wound treatment. These deficient practices likely result in the resident not receiving the appropriate type of treatment to prevent and treat infection that may possibly result in death. The findings are: A. Record review of the facility policy Skin Integrity and Wound Management, last revised 02/01/23, revealed the following: Practice Standards 4. Identify patient's skin integrity status and need for prevention or treatment interventions . 6. The licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds; . 6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change in condition. 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds . B. Record review of R #1's EHR (Electronic Health Record) revealed that R #1 was admitted to the facility on [DATE] with the following pertinent diagnoses: peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), onset date: 09/01/22 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325038	A. Building B. Wing	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	artherosclerosis (thickening or hardening of the arteries caused by a buildup of plaque) of the native arteries of extremities (5 lower extremity arteries- femoral artery, the superficial femoral artery, the popliteal artery, the posterior tibial artery, and the dorsalis pedis artery) with rest pain, left leg, onset date: 09/01/22 prediabetes (blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes), onset date: 11/05/22 methicillin resistant staphylococcus aureus (MRSA- Methicillin-resistant Staphylococcus aureus- an infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics) infection, unspecified site, onset date: 02/2/23 cellulitis (bacterial skin infection) of left lower limb, onset date: 02/25/23 infection following a procedure, other surgical site, subsequent encounter, onset date: 02/25/23 C. Record review of hospital documentation, encounter dates from 01/09/23 to 01/16/23, revealed that R #1 was hospitalized for the status of his ischemic ulcers (slow healing wounds as a result of poor blood circulation). After previous treatments, testing revealed that amputation [surgical removal of limb] was unavoidable. On 01/11/23 he underwent an above the knee amputation (AKA) of his left leg. D. Record review of physician orders revealed the following wound care orders for R #1's LAKA (Left Above Knee Amputation) 1. 01/19/23 to 01/23/23, Wound(s): Monitor site(s) Daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), if applicable Additional Documentation in NN [nursing notes] if needed s/p [status post] LAKA every day and night shift 2. 01/21/23 to 02/25/23, Wound Care LAKA: Cleanse with wound cleanser, pat dry, apply Adaptic dressing [type of wound bandage], apply 4x 4 [inches] gauze, wrap with kerlix [type of wound bandage] and ACE bandage. Apply stump shrinker [a compression garment to help shape the limb] every other day, one time a day every other day for wound care [wound care orders began 11 days after amputation] E. Record review of the TAR (Treatment Administration Record) revealed the following documentation of wound care administration and resident refusals: January 2023: Physician order, date 01/21/23-02/25/23, Wound Care LAKA: Cleanse with wound cleanser, pat dry, apply Adaptic dressing, apply 4x4 gauze, wrap with kerlix and ACE bandage. Apply stump shrinker. every other day one time a day every other day for wound care. Wound care was not documented as being administered or if the patient refused (blank) on the following dates: 01/21/23 and 01/29/23. February 2023: (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R #1 refused wound care on 02/10/23 and 02/18/23. March 2023: Physician order, dated 03/11/23-03/14/23, Wound Care: Left AKA - clean with sound cleanser, pat dry, apply adaptic gauze, and cover with border gauze. one time a day for wound care R #1 refused wound care on 03/12/23 Physician order, dated 03/14/23-04/03/2023, Wound Care: Left AKA - clean with sound cleanser, pat dry, apply adaptic gauze, and cover with border gauze. every evening shift for wound care. R #1 refused wound care on the following dates 03/14/23, 03/19/23, and 03/21/23. Wound care was not documented as being administered or if the patient refused on the following dates: 03/15/23, 03/17/23, and 03/18/23. April 2023: Physician order, dated 04/05/23, Wound Care: Left Stump - clean with wound cleanser, apply thick layer of Santyl to all necrotic areas of the wound. Apply Opticell AG(ok to use Maxosorb Ag) to wound and cover with border gauze. every day shift for left stump wound care R #1 refused on the following dates: 04/07/23, 04/09/23, 04/13/23, and 04/15/23. Wound care was not documented as being administered or if the patient refused on the following dates: 04/10/23 and 04/12/23. F. Record review of the weekly wound assessments revealed the following documentation for all LAKA wound assessments: 11/17/22- Venous wound [A wound on the leg or ankle caused by abnormal or damaged veins to left shin]. Total area: 42.6 cm. 8.2 X 5.2 0.3 (length by width by depth in centimeters). Improving. 11/28/22- Venous wound to left shin. Total area: 41.6 cm. 8.0 X 5.2 X 0.1(length by width by depth in centimeters). Improving. 12/15/22- Venous wound to left shin. Total area: 37.5 cm. 7.5 X 5.0 X 0.3 (length by width by depth in centimeters). Stable. 02/08/22- Surgical wound to left knee. Total area: 21.9 cm. 7.2 X 4.3 X N/A (depth not applicable on surgical wound). Wound bed: eschar 100%. Edges: attached. Surrounding tissue: black and blue. Goal of care: monitor/manage- wound healing not achievable due to untreatable underlying conditions. Deteriorating. (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	04/04/23- Surgical wound to left knee. 0 sutures, Incision Approximated. Total area: 43.4 cm. 10.4 X 6.5 X N/A (depth not applicable on surgical wound). 30% granulated [the development of new tissue and vessels], 40% slough [the accumulation of dead cells that are yellow/white in appearance], 30% eschar [necrotic tissue that needs to be removed to promote wound healing], moderate drainage- seropurulent [a type of drainage that is a usual sign of infection]- no odor, non-attached edges [open wound], surrounding skin- erythema (redness to skin), no swelling, dressing intact. Generic wound cleanser. Debridement- enzymatic. MD [medical doctor] diagnosed infection. Using santyl ointment for enzymatic debridement [the application of a prescribed topical agent that chemically liquefies necrotic tissues with enzymes]. Resident on antibiotics. Practitioner notified. G. Record review of nursing notes related to wound care of the left limb revealed the following: 12/06/22- wound assessment done 12/13/22- IDT [Interdisciplinary Team meeting]- [Name of R #1] has refused wound assessment and treatments. He states that clinic will change. Educated him increased risk of infection and that the clinic wrote orders for wound care to be done here. He states that he doesn't care. 12/19/22- wound assessment done 12/22/22- wound care done by wound clinic 12/28/22- wound clinic did wound care 01/04/23- Resident went to wound clinic today. New orders given. Wound to left lower leg measures 6 cm (centimeters) x (by) 3.8cm x 0.3cm with a moderate amount of serous exudate [a thin liquid that drains from the wound, usually a part of a normal wound healing process] and is erythematous [redness of the skin]. 02/08/23- A deteriorating [worsening] surgical wound in-house acquired Location: Left Knee was assessed today 03/07/23- Wound vac removed by [name of outside prosthetic consultant] and dressing change done at this time as well 04/04/23- Left Knee was assessed today 04/05/23- Resident refused to shower this shift and refused dressing changes 04/06/23- Wound care provided 04/07/23- Refused wound care 04/13/23- Resident asked 3x [three times] to do wound care and refused 04/14/23- Wound dressing changed 04/15/23- Resident refused X 3 today stating 'Can you just do it tomorrow' (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	04/17/23- Resident refused to let writer do his dressing H. On 04/24/23 at 12:13 pm, during an interview with the Wound Nurse, she explained that she recently stepped into the position of being the wound care nurse. When asked to explained her role in the facility she explained, I became the skin health lead [wound nurse] in April [2023]. Before I became the skin health lead, the staff who would do the assessment would be the floor nurse. The floor nurse would be the ones who would have charted and communicated with the doctor . It was up to the floor nurse to assess the wounds. When asked to explain her interactions with R #1, she explained According to the nurses on duty, he was refusing wound care pretty often. He started off with a venous wound and they had to do the amputation [01/11/23], he was refusing a lot of the time. He was very persistent and would say 'no, not today or how about tomorrow'. At that time, I wasn't the team lead yet. Then he had a further amputation [02/23/23] and after that he would refuse treatments fairly often. I would tell the nurses to document his refusals. The last time I saw him [04/04/23], he went to the hospital, his surgical site was completely necrotic [dead tissue]. When he came back [02/25/23] they must have debrided [to remove damaged tissue] it because it was open and raw. I. Record review of nursing notes, dated 01/16/23, revealed Resident readmitted to facility today after LLE [Left Lower Extremity] AKA . When I informed resident that I would need to check his skin and do his admission, he states 'I just don't want to be bothered today. I just want to relax, smoke a cigarette, and watch the football game. Just do it all tomorrow.' Further review of nursing notes dated 01/18/23, revealed Spoke with [name of outside prosthetic consultant] regarding leg amputation care. [Name of outside prosthetic consultant] will visit resident tomorrow [01/19/23] and will contact surgeon for dressing orders. Will continue to monitor surgical site and notify surgeon with concerns/changes. J. On 04/24/23 at 12:37 pm, during an interview with Licensed Practical Nurse (LPN) #2 (the author of the nursing note dated 01/16/23), when asked if R #1 returned with wound care orders on 01/16/23, she explained There should be orders, a lot of time, if he returns from the hospital and you see that he has a bandage, there should be orders. When he (R #1) readmitted on ,d+[DATE] [2023] he didn't want to do his skin assessment, so I passed that onto the night nurse. I let the night nurse know that she would have to do it. K. Record review of hospital documentation, encounter dates from 02/20/23-02/25/23, revealed that R #1 returned to the hospital due to poor wound healing. The surgical wound was found to be dehisced (a partial or total separation of previously sutured wound edges, due to a failure of proper wound healing) and infected. On 02/23/23 he required a revision (additional amputation) of his LAKA stump. During his stay, hospital documentation revealed that R #1 was ordered to receive Clindamycin [type of antibiotic] in 300 MG [milligrams] capsule. Take 1 capsule (300 mg total) by mouth every 6 hours for 21 days. Further review revealed that on 02/25/23, R #1 received a wound vac [a medical device used to suction out drainage to promote wound healing] to the LAKA. L. Record review of physician orders revealed the following: 1. An order, dated 02/25/23, for Clindamycin HCl Powder (Clindamycin HCl (Bulk)) Give 300 milligram by mouth four times a day for Wound Infection for 21 Administrations [not 21 days] (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	2. R #1 did not have any orders for wound vac care after his return from the hospital on 02/25/23, however; there was a physician order, dated 03/11/23, to Discontinue wound vac to left AKA one time only for post-op wound care for 1 day per [name of outside prosthetic consultation services]. M. Record review of hospital documentation, encounter dates from 03/22/23-04/02/23, revealed that R #1 returned to the hospital for stump pain where he was evaluated and treated for sepsis [a body's reaction to infection that causes chemicals to be released in the bloodstream to fight an infection but also triggers inflammation throughout the body leading to organ failure and often death]. Further review of the assessment and plan revealed plan for IV (intravenously) vancomycin [a type of antibiotic] until 4/20/23, followed by a few weeks of PO (oral administration) Zyvox 600 mg [milligrams] PO, BID [twice a day] (EOT [End of Treatment] 5/4/23). N. Record review of physician orders revealed that R #1 did not have an order for antibiotics after his return from the hospital on 04/02/23. O. On 04/24/23 at 2:13 pm, during an interview with the Director of Nursing (DON) , when asked what nursing staff are expected to do for wound assessments, she explained that nurses are expected to document a skin assessment on a weekly basis and if a resident refuses, the nurse should document that the resident refused. When asked to describe the process nurses follow when admitting a resident form the hospital, she explained that the nurses call the facility's physician group to confirm orders and enter the orders into the resident's EHR. When asked if the progress notes from the hospital packet are reviewed, she explained that the hospital is not consistent in sending progress notes. Sometime they do and sometimes they do not send progress notes so, it depends on what information is available. When asked if R #1 returned on 04/02/23 with a Peripherally Inserted Central Catheter (PICC) (a form of intravenous access that can be used for a prolonged period of time or for administration of medications) for vancomycin, she explained I believe there was a progress note where they said he would not be discharged with the PICC line and he would instead receive oral antibiotics. He got here and didn't have a PICC, so we just followed the discharge orders however; the antibiotics were not listed on the discharge orders. P. On 04/25/23 at 9:52 am, during an interview with the DON, when asked why R #1 didn't have wound care orders until 01/21/23, she explained, He returned on the 16th [01/16/23]and the orders didn't start until the 19th [01/19/23]. We can't put orders in, so we have to call the on-call [physician group] to get them. For him, we had numerous refusals from [name of R #1] so I think that his refusals held up the process. If we can't assess the patient then we can't let the doctor know the status, and then we can't get orders. The person who did his admission [on 01/16/23] was an agency nurse and if she didn't know that he had a wound and he was refusing, then she wouldn't have known to requested them. When asked if she should have been aware of his amputation through the hospital documentation, she explained For admissions, we don't usually get packets [hospital stay documentation] with the residents. We can call and call and they [the hospital] will never answer the phone. When asked if the nurse should have notified the physician of his refusal to assess him upon admission, she stated Yes, she should have notified the physician. Q. On 04/25/23 at 12:09 pm, during an interview with the DON, when asked if R #1 should have received physician's orders for wound vac care, she explained We didn't have wound vac orders until 03/01/23. It [the physician's order] should have been more specific from the hospital. We cannot put the wound vac on [without a doctor's order] because it is a specialty device. The doctor should have given us a clear order. We did not call to get clear orders. We should have called to get clear orders. (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R. On 04/25/23 at 2:59 pm, during an interview with the DON, when asked if the order for Clindamycin should have been administered for 21 days, she confirmed yes and explained that while entering the order into the EHR, it was done incorrectly for 21 Administrations. S. Record review of nursing notes, dated 04/14/23, revealed Resident [R #1] approached this nurse [RN #1] with a paper from an appointment he had on 4/11/23. The paper appears to be a copy of a progress note from a wound care visit. The paper requested the resident be admitted to the hospital for wound treatment. This nurse along with unit manager [RN #4] discussed this with the resident and he refused to go to the hospital. T. Record review of hospital follow-up visit, as noted by the infectious disease doctor, dated 04/11/23, revealed We may presume the wound problem is related to MRSA (methicillin resistant staphylococcus aureus) though at this point he could have secondary nosocomial pathogens superimposed. Also high risk for osteomyelitis [infection from nearby tissue that spreads to the bone] at femur [thigh bone] . Further review revealed 76 yo [year old] man with severe PAD [Peripheral Arterial Disease]. Here for wound and antibiotic assessment. His wound isn't better . He says he is NOT on IV medications (vancomycin). Assessment and Plan: Refractory LAKA stump wound infection now with dehiscence [partial or total separation of wound edges, due to a failure of proper wound healing] and necrotic eschar [dead tissue]. He is not systemically ill acutely, but wound appears worse now than he did in hospital. He has not been receiving the Rx [prescription] I advised. Seems he isn't on any antibiotics and has not had good wound care. Recommend: Readmit to hospital for wound care, debridement, antibiotics. I indicated this in writing to the SNF [Skilled Nursing Facility] (don't know medical contact there) and gave letter to patient. As advised in hospital: Zyvox 600 mg po BID for 10-14 days . U. Record review of EHR revealed that R #1 passed away on 04/17/23 while in the facility. V. On 04/26/23 at 2:21 pm, during an interview with the DON, when asked how communication is executed between the facility and outside care, she explained that if there is a change in treatment, she expects the outside care provider to send the facility documentation of treatment changes. When asked about the note from R #1's follow-up visit on 04/11/23, she explained that the facility did not receive the note and that the outside care provider should have been more clear with his recommendations. When asked why a facility nurse didn't call to request notes from the follow-up visit, she explained, We have a lot to do in the facility. I would expect them [outside clinic] to send it. We probably did assume that there were no changes for him. When asked if the facility should have some type of communication process between outside providers, she confirmed yes. W. On 05/01/23 at 10:54 am during interview with the Administrator and Director of Nursing, the Administrator (DON) stated It was common knowledge that his [R #1] wound was infectious. Administrator and DON stated that R #1 would consistently refuse wound care. X. On 05/01/23 at 11:57 am during interview with the Wound Nurse (WN), regarding R #1, she stated I wasn't the only one seeing his [R #1's] skin. They [nurses] are supposed to be doing the wound assessments. The WN confirmed that she had heard [from staff] that he [R #1] was refusing wound care but wasn't aware that it was happening consistently. She confirmed that she had seen the wound one week and then the next week, he (R #1) let her look at his skin except the wound. The WN confirmed that she only saw the wound one time. When asked how can she be sure the wound care orders were still appropriate if she hadn't seen the wound, she said that the nurses would be expected to let her know. (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	This resulted in an Immediate Jeopardy (IJ) at a scope and severity of J which was announced in-person on 04/28/23 at 2:00 pm to the Center Executive Director. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 04/28/23. Implementation of the POR was verified onsite on 05/01/23 at 4:20 pm by conducting record reviews and staff interviews. Plan of Removal: The Immediate Jeopardy finding was identified in the following area: Failure to consistently document, assess, monitor and notify the physician when a wound became worsened potentially because antibiotic treatments were not accurately provided . All residents have the potential to be affected by this alleged deficient practice. The following measures and monitoring will be completed by 4/29/23: - On 4/24/23 the nursing team (Director of Nursing responsible) initiated a 30-day audit on all antibiotics to ensure all orders are accurate with the correct duration/routes. Any discrepancies will include a provider notification and review to ensure accurate medication orders are in place. - On 4/25/23 the nursing team (Director of Nursing responsible) 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. Systematic Measures: Beginning 4/28/23 the Center Nurses will be re-educated on the following areas: - 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). - Nurses will be educated on proper wound processes which include accurate (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation for wounds/wound changes, change in condition when a wound is new or worsened, appropriate treatment options, weekly skin checks, wound measurements, and signs and symptoms of a wound infection. If a resident is consistently refusing needed interventions such as wound assessments and treatment, the provider needs to be notified immediately so further interventions can be placed if necessary. All communication needs to be documented in the change in condition documentation, or follow-up documentation. All refusals need to be documented in the chart, and the care plan should be updated including interventions. - Medication reconciliation process, and reviewing clinic notes when a resident returns from an appointment. If there are clarification questions at that time, the nurse should call the clinic and get clarification immediately. Clear documentation needs to occur for medication reconciliation, as well as when communication occurs to providers or outside clinics. Clinic notes and follow-up will be reviewed by nurse managers to ensure correct orders and plan of treatment are initiated. The IP Nurse will track all new antibiotics on admission and as they are ordered within the center to ensure the order is correct, being tracked for antibiotic stewardship, and that providers have been involved and want to continue therapy after 48 hours. The Director of Nursing/Designee will send a letter to all outside providers/clinics requesting that documentation from resident appointments be given to the van driver following the appointment. Documentation will be given to the Receptionist/Designee for distribution to Nursing and Medical Records. If there is no documentation delivered following an appointment, the Receptionist will follow up with the provider and work with Medical Records to get the documentation needed to provide continuity of care. The Nurse Educator/designee will begin education 4/28/23. As of 5/1 /23 100% of available staff (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	05/01/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	have been educated on these processes. Any staff member that has not been scheduled, on leave of absence (FMLA), vacation, or PRN staff will be educated prior to returning to their next shift. Quality Assurance and Monitoring The Director of Nursing/Designee will audit education sign-off sheets to ensure that all nursing staff receive the education mentioned above. The Medical Records Director will audit resident appointments for follow-up documentation. The Director of Nursing/Designee will conduct random audits weekly for wound care and antibiotics and will provide any needed immediate interventions. An Ad Hoc QAPI Meeting will be held on 5/1/23 to approve the above plan. The DON/designee and the Administrator/designee will bring the results of the audits to the QAPI committee for tracking, trending and further recommendations to ensure compliance with plan. The audits will be brought to the QAPI committee for 3 months. The Administrator will oversee the QAPI committee.

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	05/01/2023

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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 47899 Based on record review and interview, the facility failed to provide the necessary care to effectively treat pain for 2 (R #1 and R #3) of 3 (R #1, R #3, and R #4) residents reviewed for having pain medication available. This deficient practice likely resulted in residents experiencing significant pain without sufficient relief. The findings are: Findings for R #1 A. Record review of R #1's physician orders dated 04/03/23 revealed, Oxycodone (narcotic pain medication)-Schedule ll (The drug of other substance has a high potential for abuse and has a currently accepted medical use in treatment in the US or a currently accepted medical use with severe restrictions. Abuse of drug or other substances may lead to severe psychological or physical dependence) tablet (tab); 10 mg (milligrams); Amount to administer; 1 tab, oral (by mouth), every 6 hours-PRN (as needed) for pain. B. Record review of the Electronic Medication Administration Record (EMAR) revealed R #1 was getting Oxycodone 10 mg PRN (as needed) for pain every 6 hours. Resident reported the medication was ineffective eight times, and it was unknown if it was effective twice. This was documented by the nurses in the EMAR when they (nurses) have to go in and say if a pain medication was effective or not. This was reported from 04/04/23 to 04/11/23. C. Record review of R #1's provider progress note dated 04/11/23 revealed, R #1 expressed frustration about not getting enough pain medication when he spoke with infectious disease provider. When he was at this appointment for follow up on 04/11/23. D. On 04/26/23 at 12:32 pm during an interview with Registered Nurse (RN) #1, stated, Pain he kept asking like it was effective when they switched him to Lyrica (this medication is used to treat pain caused by nerve damage due to diabetes, shingles (herpes zoster) infection, or spinal cord injury), and Oxycodone, but it didn't last him. E. On 04/26/23 at 1:13 pm during an interview with Prosthetic Consultant replied, He (R#1)had a neck issue, and had a lot of back pain, he was hunched back. He did have residual limb pain; I have seen many of the amputees have pain like he did. F. On 04/26/23 at 2:21 pm during an interview with Center Nurse Executive (CNE), she stated, His pain management was adjusted by our Medical Director. The pain process is based on people's history, dependence, and tolerance. It will look different. If a change needs to be made, then the provider will be the one that determines that. R #1 pain assessments revealed his pain levels were rated at a 7 to 9 out of a 10 pain score and that the pain medication was not effective, and no notes stating the provider was notified that the pain medication was not effective. Findings for R #3 (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	05/01/2023

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 0697 Level of Harm - Actual harm Residents Affected - Some	G. On 04/27/23 at 9:30 am during an interview with R #3, he stated, Yes, I have a lot of pain. More so a night than in the day. Last night I asked for pain medication, and they never brought them to me. The same thing this morning. I have always had that problem of them not giving me my medications. H. On 04/27/23 at 9:42 am during an interview with RN #4, she stated, Oh, another fun one. He is tough. His pain is mostly at night, and it is his legs. During the day we do his wound care. He doesn't complain about pain during the day. RN #4 stated, He did ask for pain medication this morning and I forgot to give it to him. I. Record review of EMAR revealed that the resident didn't receive any pain meds (medications) on 04/21/23 he complained of a 7/10 pain level (This pain scale is most commonly used. A person rates their pain on a scale of 0 to 10 or 0 to 5. Zero means no pain, and 5 or 10 means the worst possible pain. These pain intensity levels may be assessed upon initial treatment, or periodically after treatment). EMAR revealed that on 04/27/23 at 9:30 am when he complained of pain, he was given nothing, and his pain level was recorded in the Emergency Treatment Administration Record (ETAR) at 0.

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	05/01/2023

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 - Actual harm Residents Affected - Few	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** 47899 Based on record review and interview, the facility failed to ensure residents were receiving behavioral health for 1 (R #1) of 3 (R #1, R #3, and R #4) residents reviewed for behavioral health concerns. This deficient practice likely resulted in R #1 not receiving behavioral or mental health care and assistance needed to improve and reduce depression and anxiety. The findings are: A. Record Review of R #1's hospital record dated 01/15/23 revealed R #1 had limited social and family support. R #1 did not have a stable living environment and had been living at the [Name of Nursing Home]. Nursing home prior to hospitalization . The resident was also protective regarding his room at [Name of Nursing Home] and he feels the need to have his pants on so that it will define his leg [due to amputation]. B. Record review of the Electronic Medication Administration Record (EMAR) revealed that R #1 was on Amitriptyline (from a group of medicines called tricyclic antidepressants) for depression to be given 1 tablet at bedtime. Order date was 04/03/23. C. Record Review of the Minimum Data Set (MDS) Section D (SECTION D: MOOD Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity) for 04/11/23 revealed that R #1 had little interest and feels down or hopeless. R #1 was marked yes for depressed. D. On 04/25/23 at 2:59 pm during an interview, the Center Nurse Executive (CNE) was asked if the resident was receiving any psych services (services included in the branch of medicine that treats mental and neurotic disorders and the pathologic or psychopathologic changes associated with them). She replied, I'm not sure. That's Social Services' responsibility, you'd have to ask them. E. On 04/25/23 at 12:31 pm during an interview, the Social Services Director (SSD) stated, I remember when I first met him (R #1) and we always talk to our residents about Psych (psychological services). I did bring it up, and [Name of R #1] got offended and said, 'I'm not crazy.' She (SSD) didn't remember when, and no documentation was found. SSD never received an order for Psych services referral. SSD was never approached by anyone telling her that R #1 needed any Psych services, and her evaluation in the MDS is a standardized assessment tool that measures health status in nursing home residents. F. On 04/26/23 at 1:13 pm during an interview with Prosthetic Consultant services stated, Nurses stated that he was depressed. I think everybody noticed it and was aware of it. He was depressed and upset. I follow a lot of amputated patients they tend to get into a [NAME]. He was not happy. He was not happy with it, any of it. He felt like a burden because he wasn't getting what he wanted from the facility. The Nurses and Doctors didn't care. They didn't give him the time of day. Didn't pay attention to him. He would get frustrated. The nurses would just say 'He is depressed.' G. On 04/26/23 at 2:21 pm during an interview with the CNE, she stated that R #1 would not benefit from Psych services. He doesn't trust anyone. This is his home. It's the kind of guy he was. We know our residents and he wouldn't have spoken to anyone.

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	05/01/2023

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 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 performed a medication error for 1 (R #1) of 3 (R #1, R #2, and R #3) resident reviewed for wound treatment by not: 1. Transcribing (accurately copy physician orders into the resident's chart) medication administration orders correctly and; 2. Not requesting clarifying orders from the hospital for antibiotic treatment, and follow-up consultation/recommendation notes. These deficient practice likely resulted in a resident not receiving proper treatment for a wound infection. The findings are: A. Record review of R #1's Electronic Health Record (EHR) revealed that R #1 was admitted to the facility on [DATE] with the following pertinent diagnoses: peripheral vascular disease, onset date: 09/01/22 arteriosclerosis of the native arteries of extremities with rest pain, left leg, onset date: 09/01/22 prediabetes, onset date: 11/05/22 methicillin resistant staphylococcus aureus infection, unspecified site, onset date: 02/2/23 cellulitis of left lower limb, onset date: 02/25/23 infection following a procedure, other surgical site (above the knee of left leg), subsequent encounter (after the patient has received active treatment), onset date: 02/25/23 B. Record review of hospital documentation, encounter dates from 01/09/23-01/16/23, revealed that R #1 was hospitalized for the status of his ischemic ulcers (slow healing wounds as a result of poor blood circulation) located on his left shin. After previous treatments, testing revealed that amputation (surgical removal of limb) was unavoidable. On 01/11/23 he underwent an above the knee amputation (AKA) of his left leg (LAKA). C. Record review of hospital documentation, encounter dates from 02/20/23-02/25/23, revealed that R #1 returned to the hospital due to poor wound healing and required a revision (additional amputation) of his LAKA (Left Above Knee Amputation) stump. During his stay, hospital documentation revealed that R #1 was ordered to receive Clindamycin [type of antibiotic] in 300 MG [milligrams] capsule. Take 1 capsule (300 mg total) by mouth every 6 hours for 21 days. D. Record review of physician orders, dated 02/25/23, revealed an order for Clindamycin HCl Powder (Clindamycin HCl (Bulk)) Give 300 milligram by mouth four times a day for Wound Infection for 21 Administrations [not 21 days] (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	05/01/2023

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 0760 Level of Harm - Actual harm Residents Affected - Few	E. Record review of the Medication Administration Record (MAR) for February and March of 2023 revealed that R #1 received Clindamycin HCl Powder for 6 days: 02/25/23, 02/26/23, 02/27/23, 02/28/23, 03/01/23, and 03/02/23. F. On 04/24/23 at 11:44 am, during an interview with the facility's physician, she confirmed that the order for Clindamycin was transcribed incorrectly for 21 administrations instead of 21 days. G. Record review of hospital documentation, encounter dates from 03/22/23-04/02/23, revealed that R #1 returned to the hospital for stump pain where he was evaluated and treated for sepsis (the body's response to an infection that results in organ failure and sometimes death). Further review of the assessment and plan revealed plan for IV (intravenously) vancomycin [a type of antibiotic] until 4/20/23 followed by a few weeks of PO (oral administration) Zyvox (an antibiotic used to treat bacterial infections) 600 mg [milligrams] PO BID [twice a day] (EOT [End of Treatment] 5/4/23). H. Record review of physician orders revealed that R #1 did not have an order for an antibiotic after his return form the hospital on 04/02/23. I. Record review of hospital follow-up visit, as noted by the infectious disease doctor, dated 04/11/23, revealed We may presume the wound problem is related to MRSA (methicillin resistant staphylococcus aureus) though at this point he could have secondary nosocomial pathogens superimposed [microorganisms that may have been contracted while receiving care at the hospital]. Also high risk for osteomyelitis [infection from nearby tissue that spreads to the bone] at femur [thigh bone] . Further review revealed 76 yo [year old] man with severe PAD [Peripheral Arterial Disease]. Here for wound and antibiotic assessment. His wound isn't better . He says he is NOT on IV medications (vancomycin) [antibiotic]. Assessment and Plan: Refractory LAKA stump wound infection now with dehiscence [partial or total separation of wound edges, due to a failure of proper wound healing] and necrotic eschar [dead tissue]. He is not systemically ill acutely, but wound appears worse now than he did in hospital. He has not been receiving the Rx [prescription] I advised. Seems he isn't on any antibiotics and has not had good wound care. Recommend: Readmit to hospital for wound care, debridement, antibiotics. I indicated this in writing to the SNF [Skilled Nursing Facility] (don't know medical contact there) and gave letter to patient. As advised in hospital: Zyvox 600 mg po BID for 10-14 days . J. On 04/24/23 at 2:13 pm, during an interview with the Director of Nursing (DON), when asked to describe the process nurses follow when admitting a resident form the hospital, she explained We put in orders from the hospital, and we call the on-call providers or [name of facility's medical group] and we clarify orders. Nurses always have to clarify the orders and then we put them in the system. We fax the admission orders to the doctor, and we talk over the phone and verify if it is correct and pharmacy will do a medication review to ensure that everything was transcribed correctly into [name of EHR platform]. When asked if the progress notes from the hospital packet are reviewed, she explained It depends, sometimes we only get discharge orders or progress notes. Sometimes the doctors will request more info from the hospital. It just depends on what the hospital sends us. When asked if R #1 returned on 04/02/23 with a Peripherally Inserted Central Catheter (PICC) (a form of intravenous access that can be used for a prolonged period of time or for administration of medications) for vancomycin, she explained I believe there was a progress note where they said he would not be discharged with the PICC line and he would instead receive oral antibiotics. He got here and didn't have a PICC, so we just followed the discharge orders however; the antibiotics were not listed on the discharge orders. (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	05/01/2023

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 0760 Level of Harm - Actual harm Residents Affected - Few	K. On 04/25/23 at 2:59 pm, during an interview with the DON, when asked if the order for Clindamycin should have been administered for 21 days, she confirmed yes and explained that while entering the order into the EHR, it was done incorrectly for 21 administrations. L. Record review of nursing notes, dated 04/14/23, revealed Resident approached this nurse with a paper from an appointment he had on 4/11/23. The paper appears to be a copy of a progress note from a wound care visit. The paper requested the resident be admitted to the hospital for wound treatment. This nurse along with unit manager [RN #4] discussed this with the resident and he refused to go to the hospital. M. Record review of EHR revealed that R #1 passed away on 04/17/23, while in the facility. N. On 04/26/23 at 2:21 pm, during an interview with the DON, when asked how communication is executed between the facility and outside care, she explained that if there is a change in treatment, she expects the outside care provider to send the facility documentation of treatment changes. When asked about the note from R #1's follow-up visit on 04/11/23, she explained that the facility did not receive the note and that the outside care provider should have been more clear with his recommendations. When asked why a facility nurse didn't call to request notes from the follow-up visit, she explained, We have a lot to do in the facility. I would expect them [outside clinic] to send it. We probably did assume that there were no changes for him. When asked if the facility should have some type of communication process between outside providers, she confirmed yes.