STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA FE CARE CENTER	635 HARKLE ROAD 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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report a witnessed fall with injury that occurred on 03/15/20 and ensure that a five day follow up investigative report was submitted to the State Agency (SA) for 1 (R #1) of 4 (R #s 1, 2, 3 and 4) residents reviewed for facility reported incidents. If the facility fails to send the required incident report and a 5-day follow-up investigative report to the Licensing Authority, the State Survey Agency will not be able to determine whether a thorough investigation was completed or if appropriate measures of correction were put in place in a timely manner. The findings are: A. Record review of the medical record for R #1 revealed R #1 was admitted [DATE]. She was [AGE] years old with a medical [DIAGNOSES REDACTED]. reversible obstruction),[MEDICAL CONDITION](Gastric reflux disease), calcus in bladder (stones), urinary incontinence, history of UTI's, history of falling, Stage III kidney disease (occurs when your kidneys lose the ability to filter waste from your blood sufficiently) and [MEDICAL CONDITION] (joint pain and stiffness). B. Record review of the Nurses notes dated 03/16/20 at 03:50 am stated the following: Note Text: At approximately 1900 (7:00 pm) res (resident) was sitting near nurses station in front of the couch sitting in her wheel chair next to her roommate talking, res stood up as she was talking, fell forward and hit her right side of her head, res has a goose egg bump on right side of head, res refused any pain medication, res bp (blood pressure)148/72, T (Temperature) 96.8, P (Pulse /heart rate) 71, R (Respirations) 87% on RA (Room Air), res later developed a black right eye and swollen right side of her forehead with bruising, res granddaughter was notified, res was monitored throughout the shift with no neuro changes (to ensure that there is no [MEDICAL CONDITION]) noted. On-call MD notified, on-call supervisor notified. The fall occurred on 03/15/20 but was not charted until 03/16/20 as noted above. There were no Nurses notes dated 03/15/20. C. Record review of the facility fall incident reports dated 02/29/20 through 06/26/20 revealed no documentation identifying R #1 had any falls during this time period even though it was documented in the nurses notes as stated above. D. On 06/29/2020 at 11:00 am, during interview, the Director of Nursing stated she could not find an incident report for the fall that R #1 sustained on 03/15/20 but they did review it in their IDT (Interdisciplinary Team) meeting. There was no evidence of a facility self-report or 5 day follow up received by SA. E. On 06/29/20 at 2:48 pm, during interview, the Administrator was asked to explain the process and protocol for post fall assessments and required documentation. The Administrator stated that they review all falls in IDT meeting the following morning and check to see if there are nurses notes, a completed fall risk assessment, were neuro checks initiated, was the care plan updated and if an incident report hadn't been done. She said there would be an IDT note documenting the documentation had been completed. When asked if she (the Administrator) was aware of state agency requirements to report incident events to the state, she stated, Yes. The Administrator was then made aware that no incident or investigative report had been reported to the State Agency regarding the fall with a head injury that R #1 suffered on 3/15/20. When asked if this could be explained, she stated that they were trying and know they are not perfect but did agree that it was a problem. The Administrator was then made aware that with this particular event there was no evidence the incident was reported to the State Agency. The Administrator stated that she felt that as long as there was an IDT note, updated care plan and nursing documentation that this would demonstrate the incident was investigated.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to conduct an investigation from a witnessed fall with injury that occurred on 03/15/20 for 1 (R #1) of 4 (R #s 1, 2, 3 and 4) residents reviewed for facility reported incidents. If the facility fails to conduct a thorough investigation, corrective measures will not be put in place resulting in a potential increase of falls in the future. The findings are: A. Review of the medical record for R #1 revealed R #1 was admitted [DATE]. She was [AGE] years with a medical [DIAGNOSES REDACTED]. of falling, Stage III kidney disease and [MEDICAL CONDITION] (joint pain and stiffness). B. Review of the Nurses notes dated 03/16/20 at 03:50 am stated the following, Note Text: At approximately 1900 (7:00 pm) res (resident) was sitting near nurses station in front of the couch sitting in her wheel chair next to her roommate talking, res stood up as she was talking, fell forward and hit her right side of her head, res has a goose egg bump on right side of head, res (resident) refused any pain medication, res bp (meaning Blood Pressure) 148/72, T (Temperature) 96.8, P(Pulse/heart rate) 71, R(Respirations)87% on RA(Room Air), res later developed a black right eye and swollen right side of her forehead with bruising, res granddaughter was notified, res was monitored throughout the shift with no neuro changes (changes that may indicate a [MEDICAL CONDITION]) noted. On-call Medical Director (MD) notified, on-call supervisor notified. The fall occurred on 03/15/20 but was not charted until 03/16/20 as noted above. There were no Nurses noted dated 03/15/20. C. Review of the facility fall incident reports dated 02/29/20 through 06/26/20 revealed no documentation identifying R #1 had any falls during this time period even though it was documented in the nurses notes as stated above. D. On 06/29/20 at 11:00 am, during interview the Director of Nursing stated she could not find an incident report for the fall that R #1 sustained on 03/15/20, but they did review it in their IDT (Interdisciplinary Team) meeting. E. Review of the Progress notes dated 03/11/20 to 04/10/20 revealed no documentation that would indicate an IDT meeting took place to discuss this incident. F. Review of the Care Plan for R#1 dated- Date initiated 06/26/20, revealed R #1 was at risk for falls and the fall that occurred on 03/15/20 as documented. Under 'Interventions' there is a note describing the fall and states, Fall protocol in place, no changes in mental status. Nursing to monitor her till bruising (developed a black right eye and swollen right side of her forehead with bruising) resolved. She was in the common area, so staff could monitor but no staff close enough to prevent her fall. Continue to monitor her frequently and remind her not to get out of chair/bed without asking for help. She has dementia so staff must remind frequently. Staff to ensure w/c (wheel chair) brakes are locked when in chair. DOR (Director of rehab) alerted of fall. G. On 06/29/20 at 2:48 pm, during interview with the facilities Administrator was asked to explain the process and protocol for post fall assessments and required documentation. The Administrator stated that they review all falls in IDT (IDT meets daily) meeting the following morning and check to see if there is nurses notes, a completed fall risk assessment, were neuro checks initiated, was the care plan updated and if an incident report hadn't been done. She said there would be an IDT note documenting the documentation had been completed regarding the fall with a head injury that R #1 suffered on 3/15/20. The Administrator was then made aware that with this particular event there was a lack and /or absence of documentation; no indication neuro checks were initiated and completed, no documentation that R #1's vital signs were being monitored or a thorough investigation was completed. When asked if this could be explained, she stated that they were trying and knows they are not perfect but, did agree that there were ongoing problems.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.**

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

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.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents receive treatment and care per physicians orders and in accordance with professional standards of practice for 4 (R #1, 3, 4 and 6) of 4 (R # #1, 3, 4 and 6) residents reviewed for falls and deaths as part of a complaint investigation. This deficient practice is likely to result in residents not being appropriately monitored for post falls when potential changes in mental status are not noticed and /or changes in health status are not identified or recorded, resulting in delaying emergency treatment. The findings are: A. Review of the Facilities Policy, 'Neurological Assessment states the following; 1. Neurological assessments are indicated: a. Upon physician order; b. Following an unwitnessed fall; Following a fall or other accident/injury involving head trauma; or when indicated by the resident's condition. 2. When assessing neurological status, always include frequent vital signs (Blood pressure, pulse, respirations, temperature and oxygen saturation) B. Review of the policies, 'Blood Pressure, Measuring, Apical and Radial Pulse Measuring, Respiration Measuring and Pulse Oximetry (assessing Oxygen Saturation) all stated the following under 'Documentation'; The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The BP, Pulse, Respiration rate . Findings for R #1: C. Review of the medical record for R #1 revealed R #1 was admitted [DATE]. She was [AGE] years old with a medical [DIAGNOSES REDACTED]. of falling, Stage III kidney disease and [MEDICAL CONDITION] (joint pain and stiffness). The Office of the Medical Examiner declined to take the case and the facility did not have cause of death. D. Review of the Admission/Transfer Orders dated [DATE] signed by physician indicated the following orders; Vital Signs including O2 Sat (oxygen saturation): on Admission ([DATE]), Daily X3 Days, then weekly. Oxygen: -No, O2 sat (frequency): weekly . E. Review of the Physicians Progress Note dated [DATE] stated; There have been very few vital signs recorded but there are no significant abnormalities other than an initial blood pressure that was low. F. Review of the Vital Signs Summary reports for R #1 dated [DATE] through [DATE] revealed the following; Vital Sign documentation: 1. [DATE] BP (Blood Pressure) ,[DATE], P (pulse) 56, BPM (breaths per minute) 16, O2 Sat (Oxygen saturation) 93% (Room Air) 2. [DATE] BP ,[DATE], P 84, BPM 20 - No O2Sat recorded 3. [DATE] BP ,[DATE], P96, BPM 20 - No O2 Sat recorded There were no further vital sign entries documented on these reports in the R #1 EMR (electronic medical record). There were no temperatures documented except two in [DATE] and five in [DATE]. No temperature entries for the months of April or [DATE]. G. Review of the Nurse Progress notes dated [DATE] through [DATE] revealed vital signs were recorded three times during this time period; [DATE], [DATE] and [DATE]. It was also noted that on [DATE] and [DATE] R #1 had unwitnessed falls. H. Review of the Nurses notes dated [DATE] at 03:50 am stated the following, Note Text: At approximately 1900 res (7pm resident) was sitting near nurses station in front of the couch sitting in her wheel chair next to her roommate talking, res stood up as she was talking, fell forward and hit her right side of her head, res has a goose egg bump on right side of head, res refused any pain medication, res bp ,[DATE], T 96.8, P 71, R 87% on RA, res later developed a black right eye and swollen right side of her forehead with bruising, res granddaughter was notified, res was monitored throughout the shift with no neuro changes noted On-call md notified, on-call supervisor notified. There was no indication neuro checks were initiated on [DATE] when the fall occured. Further review of the nurses notes from [DATE] through [DATE] revealed R #1 experienced two other falls. One dated [DATE] and one dated [DATE]. Per documentation R #1 was assessed and had no apparent injuries reported and both were noted to be unwitnessed. I. Review of the Nursing Assessments dated [DATE] through [DATE] revealed no documented neuro checks (assessing neurological functions i.e. pupil size and level of consciousness) were initiated after R #1's fall with injury that occurred [DATE]. Findings for R #3: J. Review of the medical record for R #3 revealed R #3 was admitted [DATE] with a medical [DIAGNOSES REDACTED]. K. Review of the current Physicians orders revealed the following; Order date [DATE] - Weekly Vital signs - in the evening every Sun for V/S Q (vital signs every week)- Week L. Review of the Vital Signs Summary reports for R #3 dated [DATE] through [DATE] revealed one entry, dated [DATE]. The following vital signs were noted: BP ,[DATE], P 76, BPM 18. M. Review of the Nursing Progress notes dated [DATE] through [DATE] revealed R #3's vital signs were documented twice in that time frame on [DATE] and on [DATE]. It was also noted that on [DATE] R #3 fell . Neuro checks were performed on [DATE] and [DATE]; however, there are no vital signs on these forms. N. Review of the Treatment Administration records (TAR) dated [DATE] to [DATE] and [DATE] to [DATE] indicated that R #3's vital signs were performed, but there is no actual vital signs information recorded in notes or on the TAR itself. O. Review of the Physicians progress notes dated [DATE] stated, Patient has hardly had any vital signs recorded over the past month . P. Review of the Physicians progress notes dated [DATE] stated, There have been very few vital signs recorded over the past couple of months. Findings for R #4: Q. Review of the medical record for R #4 revealed R #4 was admitted [DATE] with a medical [DIAGNOSES REDACTED]. R. Review of the Physicians order dated [DATE] stated, Weekly Vital Signs - in the evening every Sun for weekly V/S (vital signs) S. Review of the Vital Signs Summary reports for R #4 dated [DATE] through [DATE] revealed vital signs for R #4 were documented 3 of 8 opportunities on [DATE], [DATE] and [DATE]. T. Review of the Nursing Progress notes from [DATE] through [DATE] revealed one recorded set of vital signs documented on [DATE]. U. Review of the Physicians Progress note dated [DATE] stated, No vital signs have been recorded in PCC (Point Click Care - electronic medical record system) yet for the month of June .pressures that were recorded last month were elevated .if blood pressures remain elevated in June we may consider increasing his [MEDICATION NAME] (a medication used to treat high blood pressure) dosage. Findings for R #6: V. Review of the medical record for R #6 revealed R #6 was admitted [DATE] with a medical [DIAGNOSES REDACTED]. Further review revealed R # 6 expired on [DATE]. W. Review of the Physicians orders revealed the following order dated [DATE] - Weekly Vital Signs- in the evening every Sun for Weekly V/S . When referring to taking vitals it includes 'Blood Pressure measuring, Apical and Radial Pulse Measuring, Respiration Measuring and Pulse Oximetry (assessing Oxygen Saturation). X. Review of the Treatment Administration records dated [DATE] to [DATE] and [DATE] to [DATE] indicted that R #6's vital signs were performed, but there is no actual vital signs information recorded in notes or on the TAR itself. Y. Review of the Nursing Notes dated [DATE] through [DATE] revealed two vital signs entries documented on [DATE] and [DATE]. Z. Review of the Vital Signs Summary reports for R #6 dated [DATE] through [DATE] revealed vital signs for R #6 were documented 2 of 8 opportunities on [DATE], and [DATE]. AA. On [DATE] at 11:00 am during interview, the Director of Nursing (DON) stated she has been there for two years and, the DON since [DATE]. When questioned about the frequency of taking R # 1's vital signs (Blood pressure, pulse, respirations, temperature and oxygen saturation) the DON stated, she would have been on VSS (vital signs) at least monthly. Then added that when she worked on the units before becoming DON, they did vital signs on all residents weekly. BB. On [DATE] at 2:10 pm, during interview, the Assistant Director of Nursing (ADON) was asked for a policy regarding how often VSS should be obtained and documented. The ADON stated they do monthly VSS of long term and daily VSS of Skilled (requiring skilled nursing care) residents. The ADON was then asked for a facility policy that stated this and she returned and said the polices only say how to perform the task, not how often they are to be performed or where they should be documented. CC. On [DATE] at 2:48 pm, during interview, the interim Administrator was asked how often vital signs should be taken on residents? The Administrator stated, that when she thinks of vital signs, they should be taken anytime there is a change in condition and/or every shift no matter if skilled or long-term care. The Administrator then added, normal routine vital signs for Skilled residents is every 24 hours and for long term care residents, at least every month with their weight. Also, that if a physician wrote an order for [REDACTED].? The administrator stated. No, we do not but I can type one up. There was no explanation given as to why the vital signs were not documented. DD. On [DATE] at 3:30 pm, during interview, the Physician's Assistant (PA) was asked if they have noticed a lack of VSS documentation? The PA nodded her head and agreed there was a problem with documentation but stated that it was her understanding they were done every Sunday for all residents. The PA was also made aware there were no neuro checks or post fall documentation for R #1 in the EMR, and she just shook her head (from side to side) and had no response.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for 1 (R #2) of 3 (R #'s 1, 2 and 4) residents reviewed for medications, that a prescribed medication was ordered and administered according to physician orders. If medications are not ordered and administered per physician's orders [REDACTED]. The findings are: A. Record review of a History and Physical (H and P) note dated 03/10/20, indicated that lab work completed on 02/27/20 had R #2's calcium level at 12.8 (normal levels are 8.6-10.3) which was higher than when she was admitted on [DATE]. On the plan section of the H and P, it indicated an order for [REDACTED]. B. Record review of lab work that was completed on 03/25/20, had R #2's Calcium level at 13.6 (normal levels are 8.6-10.3) which was identified by the (name of) lab as critical. The H and P indicated that an order for [REDACTED]. C. Record review of the nursing progress notes dated 3/16/20, indicated that R #2 was seen in IDT

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) (Interdisciplinary Team) meeting on 03/14/20 due to a voiced complaint of pain to left hip from a fall. A UA (urinalysis) was ordered to r/o (rule out) UTI (Urinary Tract Infection). This UA was never done. D. Record review of the physician orders [REDACTED]. Record review of the Medication Administration Record [REDACTED]. F. Record review of the physician orders [REDACTED]. Record review of the MAR for the month of April 2020 indicated that from April 9th to April 15th, R #2 received both doses of the medication on April 10th, received two doses on April 14th and one dose on April 15th. R #2 received 5 out of a possible 14 doses of the [MEDICATION NAME] Solution for Hypercalcemia. H. Record review of the physician orders [REDACTED]. Record review of the MAR for the month of April 2020 indicated that from 04/15/20 to 04/21/20, R #2 received 13 out of 14 doses of the [MEDICATION NAME] Solution for Hypercalcemia. J. Record review of the physician order [REDACTED]. Record review of the MAR for the month of May 2020 indicated that from 05/17/20 to 05/31/20, R #2 received 8 out of 15 doses of the [MEDICATION NAME] Solution Spray. L. On 06/29/20 at 1:44 pm, during an interview with the Director of Nursing (DON), she stated that more than likely the the medication did not come in for R #2 and that is why she did not get it. She stated that if a medication does not come in after it is ordered, that nursing staff need to notify her after the first day that the resident did not get the medication. The DON stated that she would have to call the pharmacy to find out what the problem was with the medication and why it hasn't come in. The DON stated that she was not sure when she was made aware of the medicine not being available for R #2. The DON did not have an answer for the inconsistencies that were noted on the MAR for this medication and why it was not ordered timely. M. On 06/29/20 at 3:43 pm, during an interview with the Physician's Assistant (PA), she stated that she had asked the DON about when R #2 would be finishing up a medication so she could order labs to check on her calcium levels. The DON looked into it and the medication had not been ordered, so the medication was ordered again. She stated that the labs did eventually get done, but not until 05/03/20.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain laboratory testing in accordance with physician orders [REDACTED].#2) of 3 (R #s 1, 2 and 4) residents reviewed for laboratory services. If the facility fails to obtain labs that have been ordered, or failed to obtain them in a timely manner, this deficient practice could cause a delay in healing, symptoms to go untreated, and a change in condition to go unidentified, causing unnecessary harm to the resident. The findings are: A. Record review of the History and Physical (H and P) completed on 02/13/20 indicated in the History of Present Illness: that resident R #2 reported difficulty with urination and some dysruia (painful or difficult urination). In the Plan section of the H and P it indicated the following should be ordered: UA with CX (culture) if indicated. Record review of the lab work indicated that a UA (urinalysis) with CX (culture) was completed on 02/28/20 two weeks after it was ordered. B. Record review of a History and Physical (H and P) note dated 03/10/20, indicated that lab work completed on 02/27/20 had R #2's calcium level at 12.8 (normal levels are 8.6-10.3) which was higher than when she was admitted on [DATE]. On the plan section of the H and P, it indicated an order for [REDACTED]. C. Record review of the MAR (Medication Administration Record) for March, indicated that an order dated 03/14/20 for lab work to be completed indicated that labs were not drawn. There is no documentation in the medical chart that indicated that these labs were drawn until 11 days later, on 03/25/20. D. Record review of the nursing progress note dated 3/16/20, indicated that R #2 was discussed in IDT (interdisciplinary team) meeting for fall with no injury on 3/14/20. Resident was assessed and voiced a complaint of pain to left hip. This was R #2's second fall in a short period of time. The note indicated that a UA (urinalysis) to be sent to r/o (rule out) UTI (urinary tract infection). E. Record review of the labs in the medical chart indicated that a UA was not completed on R #2 following the fall (to make sure there wasn't an infection contributing to R #2's falling) on 03/14/20. F. On 06/29/20 at 10:55 am, during an interview with the Director of Nursing (DON), she stated that when COVID-19 (an infectious disease caused by severe acute respiratory syndrome coronavirus) hit due to concerns about the lab techs going to other buildings and concern of bringing it into this building they were only drawing really important labs and STAT (urgent) labs. They were drawing the labs themselves and that went on for about one month. They had some issues with this as the processing lab was giving them a hard time, and there were problems with getting some of these processed and therefore the facility was really only ordering crucial labs to include STAT (urgent) PT/INR ([MEDICATION NAME] time, along with the international normalized ratio), which is a blood test used to determine the clotting tendency of blood. It was not clear on what was identifed as a STAT lab. She stated that UA's would typically get done. G. On 06/29/20 at 1:28 pm, during an interview with LPN #1 (Licensed Professional Nurse), he stated that there was period of time that they were not drawing routine labs and there was a sign posted that stated that routine labs would not be done. He stated STAT labs, PT/INR labs, and UA's, were getting done, but routine labs like CBC (Comprehensive Blood Count), or BMP (Basic Metabolic Panel) would be considered routine labs. [MEDICATION NAME] (anti-[MEDICAL CONDITION] drug) levels or [MEDICATION NAME] ((medication used to treat [MEDICAL CONDITION]) levels would also be considered routine labs. H. On 06/29/20 at 1:44 pm, during an interview with the DON, she stated that she was not sure about whether a UA was done for R #2. She stated she would check for me. The DON brought back a UA that had occurred two months later on 05/12/20 and stated that this was all she could find Results of the UA would no longer be relevant two months later. I. On 06/29/20 at 3:43 pm, during an interview with the Physician Assistant (PA), she stated that they did stop allowing the lab folks into the building. The PA stated that this was not ideal, but she was trying to compromise. She was asked not to order routine labs in March, and this went through April and into early May. The PA also stated that sometimes the labs got done and sometimes they don't. Orders for the labs are not always seen by nursing staff, so they don't always get ordered.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to implement all recommended transmission based precautions for residents newly admitted and readmitted to the facility. While caring for residents suspected of having COVID-19 during the 2020 public health emergency, these practices put 11 residents (R's #10 #11, #12, #13, #14, #15, #16, #17, #18, #19, #20) of 11 residents (R#10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20) 11 residents at increased risk for infection with COVID-19. On the date of this survey, 06/29/20, the recommended /nationally recognized transmission based precautions included: 1. Staff caring for residents that are newly admitted or readmitted should wear gowns, gloves, N95 (a face mask with the classification of air filtration, meaning that it filters at least 95% of airborne particles) face masks and goggles or face shields. If all recommended standard and transmission based precautions are not consistently adhered to, transmission of infections from person to person is more likely to occur. 2. Residents should wear a face covering and practice social distancing (keeping space at least 6 feet apart, between self and others to reduce the chance of contact with those who knowingly or unknowingly carry an illness) when out of their rooms. The findings are: A. Record review of facility policy, Isolation- Categories of Transmission Based Precautions Airborne Precautions: revised 10/2018, provided by the facility Administrator on 06/29/20 revealed, 3. Any individuals who enter the room of a resident placed on airborne precautions must wear approved respiratory protection. B. On 06/26/20 at 9:15 am, random observations were made of non quarantine residents out of their rooms, many sitting at tables in their wheelchairs. The unknown residents were not spaced 6 feet apart. C. On 06/26/20 at 9:40 am, during an interview with Certified Nursing Assistant #1 (CNA), she stated that when she goes into a room that is a quarantine room, she puts on gloves, a gown, a face shield and a mask. She stated that these (pointing to surgical masks in the cart of personal protective equipment) are the masks they wear. When asked about N95 masks, she stated that she wears this type of mask (referring to the mask she was wearing). D. On 06/29/20 at 11:00 am, during an interview, the Director of Nursing (DON) stated that with the new guidelines changing they have been cautious with PPE (Personal Protective Equipment), but have never gone without. When questioned, the DON stated, they are not using N95 masks, because when they started using them they went through 200 masks in 1 and 1/2 days. The DON also stated that no staff were fit tested (to ensure proper fit when using a N95 mask). Then added, that residents in quarantine wear a surgical mask when they are working with therapy in their rooms and if they had to be brought out of their rooms then they wear full PPE (gown /shield, gloves and mask). The DON also stated, that the rest of the residents know they have masks and most of the residents refuse to use them. When asked if the residents refusing to wear a mask, are being tracked, care planned or if a physicians order was obtained stating they did not need to wear a mask? The DON stated, No. E. On 06/26/20 at 3:30 pm, during an interview with Registered Nurse (RN) #1, she stated that only the quarantine residents have to wear a mask if they come out of their rooms. The residents can have one on or not depending if they want it, but they don't enforce residents having to wear a mask. F. On 06/29/20 at 2:48 pm, during an interview with the interim Administrator, she stated that they were trying to comply with recommendations and her interpretation of the guidelines were the words, If able meant if able to comply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA FE CARE CENTER	**635 HARKLE ROAD 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 -** Some	(continued... from page 3)