STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325034	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Albuquerque	5900 Forest Hills Drive NE Albuquerque, NM 87109

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 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** 48645 PAST NOT COMPLIANCE Based on record review and interview, the facility failed to notify the physician for 1 (R #68) of 3 (R #68, R #7, and R #49) residents, when they failed to immediately notify R #68's physician of the resident's missed seizure (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain) medications. This deficient practice result in the resident's physician being unaware of resident's current condition, resulting in delayed treatment. The findings are: A. Record review of R #68's face sheet showed the resident was admitted into the facility on [DATE] with the following diagnoses: - Traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head), - Seizures (involuntary shaking of the body), - Persistent vegetative state (chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings), - Tracheostomy [a hole surgeons make through the front of the neck and into the windpipe (trachea) so the patient can breath], - G-Tube (a tube inserted through the belly that brings nutrition directly to the stomach), - Dysphagia (difficulty swallowing). - This list of diagnosis is not all inclusive. B. Record review of R #68's physician medication order, dated 12/01/23, showed an order for levetiracetam (anti-seizure medication) oral solution, 100 milligrams per milliliter (mg/ml). Give 10 ml via G-Tube (via stomach tube) two times a day for seizure disorder. (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
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F 0580 Level of Harm - Actual harm Residents Affected - Few	C. Record review of R #68's medication administration record (MAR), dated December 2023, showed staff did not administer R #68's levetiracetam evening dose on 12/14/2023 and his morning and evening doses on 12/15/2023. D. Record review of the facility's Notification of Transfer or Discharge form, dated 12/16/23, revealed R #68 was transferred to the hospital for breakthrough seizures and low blood oxygen saturation (low oxygen in the blood stream). E. Record review of R #68's electronic medical record (EMR) and the patient's chart revealed the following: 1. A nursing progress note, dated 12/16/23 at 8:00 am, Notified by housekeeping and certified nursing aide (CNA) that the resident (R #68) isn't doing well. Vitals unstable, O2 (oxygen) saturation below 90 (normal blood oxygen saturation is between 100 and 90 percent), heart rate above 100 bpm (beats per minute) up to 150's (normal heart rate for males is 60 to 100 BPM). Oxygen concentrator applied up to 5 lpm (liters per minute), O2 (oxygen) saturation went up to 90. Seizure then started intermittently. Called POA (power of attorney) and called 911 right away. 2. The records did not contain information to show why staff did not administer the levetiracetam to R #68 on 12/14/23 evening and 12/15/23 morning and evening. 3. The records did not contain documentation to show staff notified R #68's provider about the resident's change in condition or missed medications. F. Record review of R #68's hospital discharge summary, dated 12/28/2023, stated the following about R #68's condition upon admission to the emergency roiagnom on [DATE], Prior to admission, patient had 3 episodes of tonic-clonic seizures (Tonic-clonic seizures involve both tonic (stiffening) and clonic (twitching or jerking) phases of muscle activity) that lasted approximately 1 minute each per wife. Initial seizures were not witnessed, however, patient had a subsequent seizure that lasted for approximately 20 minutes which subsequently resolved after Versed (quick acting antiseizure medication) given via EMS (emergency medical services) .Per patient's wife, she was notified on 12/20/23 that patient missed 3 doses of anti-seizure medications at facility, not just one like previously thought, possibly being the cause of breakthrough seizures. G. Record review of the facility-initiated investigation regarding R #68's missed medication, dated 12/18/2023, staff provided written statements that the levetiracetam was not available in the medication cart, and that is why staff did not administer the medication as ordered. H. On 03/26/24 at 10:36 am, during an interview with the Director of Nursing (DON), he confirmed the following: 1. The levetiracetam was not available in the medication cart in the prescribed liquid form. 2. The levetiracetam was available in the facility's Omnicell (fully automated, digital, medication storage and delivery machine) in tablet form, which could have been crushed and delivered via R #68's G-Tube. 3. The staff did not notify the provider of R #68's missed seizure medications. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	4. Staff should have notified the provider about R #68's missed seizure medications. I. Facility initiated investigation and corrective action plan, dated 12/18/2023, revealed the following: - Persons responsible for oversight Center Executive Director (CED) and Director of Nursing (DON). - Plan was specific to: Missed medications/notification of provider. - What was done: 1. DON conducted a 7 day look back audit to determine if any other critical medications were not administered due to not being available and corrected issues as they were found. 2. DON/Designees conducted a whole-house Medication Administration Record (MAR)-to-Cart audit to ensure all ordered medications were present and available in the cart. 3. Social Services Director (SSD) conducted interviews on the 300 hall to determine if any residents had concerns about receiving their medication. 4. Nursing Practice Educator (NPE)/Designee re-educated nurses/Certified Nursing Aides (CNAs) on the process of ordering medications timely and the escalation process (how to correct) to follow if medications were not available for administration. NPE will review the process with newly hired nurses/CNAs. 5. Nurses were re-educated on the process of ordering medications from the pharmacy timely (at least 5 days prior to running out) to ensure that medications remain available. Nurses were re-educated on the escalation process to follow if medications are not available to include accessing the Omnicell if medication is available within the Omnicell, notifying the medical provider, considering an alternative medication (within the Omnicell) with the medical provider, and calling the pharmacy to communicate urgency and request a STAT (NOW) delivery. 6. DON/designee conducted weekly audits of the process to ensure sustainability of the corrective action plan. This entailed a designated night nurse auditing and re-ordering medications for the cart once a week. Designated nurse submitted a list of re-ordered medications to the DON for auditing purposes. The DON reported progress to the QAPI (Quality Assurance and Performance Improvement) monthly for the next three months. J. Record review and verification of the corrective action was completed onsite. On 12/18/2023 the facility began auditing all residents in the building for any missed medications. Trainings, auditing, and verification started immediately after the facility identified the failed practice on 12/18/23. Trainings and education of staff were documented in the corrective action plan. The seven day look back audit was completed to identify any missed medications facility wide. No other residents were identified with this deficient practice at the time of the survey.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196 Based on observation, interview, and record review, the facility failed to support residents in activities of daily living by not offering showers to residents in accordance with a pre-planned and agreed upon schedule and not answering call lights in a timely manner for 3 (R #2, R #73, and R #309) of 3 (R #2, R #73, and R #309) residents sampled for ADLs. These deficient practices are likely to negatively impact resident safety, comfort, and to impede processes such as timely incontinence care (assisting residents to the bathroom or changing adult briefs) and showers. The findings are: Finding related to showers: R #309 A. Record review of R #309's care plan, revised on 03/17/24, revealed R #309 was admitted to the facility on [DATE] and required activities of daily living (ADL) assistance in bathing, grooming, personal hygiene, dressing, transfers, locomotion, and toileting. B. Record review of R #309's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment, dated on 03/13/24, revealed a Brief Interview of Mental Status (BIMS, a screening for cognitive impairment) score of 14 out of 15, cognitively intact. C. On 03/25/24 at 11:05 AM during an interview, R #309 stated she did not have a shower since she was admitted to the facility on [DATE] and would like one so she did not feel dirty. She added that she felt she needed a shower to promote good health. She stated staff offered her a shower once, but she refused since she had rehabilitation therapy at the same time. The resident stated she did not know what her shower schedule was and did not know when to expect a shower. D. On 03/29/24 at 9:13 AM during an interview, the Director of Nursing (DON) stated R #309's shower schedule was every Thursday and Sunday. E. Record review of R #309's shower sheets, dated March 2024 and provided by the facility, revealed the following: - On 03/11/24, staff offered the resident a shower, but the resident refused. - On 03/15/24, staff offered the resident a shower, but the resident refused. - The facility did not have documention staff offered the resident showers or baths during the week of 03/16/24 through 03/24/24. R #2 F. Record review of R #2's care plan, last reviewed on 03/25/24, revealed R #2 required assistance for ADL care to include bathing, grooming, personal hygiene, dressing, transfer, locomotion, and toileting. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of R #2's MDS assessment, completed on 01/19/24, revealed a BIMS score of 13 out of 15, cognitively intact. H. On 03/25/24 at 11:15 AM during an interview, R #2 stated she did not get a shower on Saturday. She stated she still wanted one, but she was told there was not enough staff today. I. On 03/29/24 at 9:13 AM during an interview, the Director of Nursing (DON) stated R #2's shower schedule was Tuesdays and Saturdays. J. Record review of R #2's shower sheets, dated March 2024 and provided by the facility, indicated the following: - On 03/12/24, the resident was not offered a shower. - On 03/16/24, the resident was not offered a shower. - On 03/19/24, staff offered the resident a shower, but the resident refused. - On 03/23/24, the resident was not offered a shower. K. On 03/29/24 at 9:13 AM during an interview, the Director of Nursing (DON) stated staff did not consistently offer R #309 and R #2 showers twice a week as scheduled, and that staff are expected to offer showers to residents twice a week as scheduled. Findings related to call light response times: R #309 L. Record review of R #309's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment, dated on 03/13/24, revealed the following: - A Brief Interview of Mental Status (BIMS, a screening for cognitive impairment) score of 14 out of 15, cognitively intact. - R #309 required substantial maximum assistance (helper does greater than 50% of the task) for toileting and transfers. M. Record review of R #309's care plan, revised on 03/17/24, revealed R #309 was at risk for falling, had a history of falls, and required assistance with ADLs including toileting and transfers. N. On 03/25/24 at 11:05 AM during an interview, R #309 stated the call light response times are very slow. She stated yesterday (03/24/24) staff did not come to assist her after she pressed her call light. After waiting for what the resident percieved to be about an hour, R #309 went to the bathroom on her own. R #73 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. On 03/28/24 at 10:41 AM during an observation, R #73's call light was on. At 11:03 AM, Certified Nursing Assistant (CNA) #1 entered R #73's room. The resident waited 22 minutes for assitance. Q. On 03/28/24 at 11:22 AM during an interview, CNA #1 stated R #73 required incontinence care. R. On 03/29/24 at 9:13 AM during an interview, the Director of Nursing (DON) stated staff should answer residents' call lights in 10 to 15 minutes, but he thought 15 minutes would be a little too long to wait for care.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196 Based on observation, interview, and record review, the facility failed to meet professional standards of care for 1 (R #309) of 1 (R #309) resident reviewed for oxygen therapy when staff failed to: - Ensure physician orders for oxygen therapy were entered into the resident's medical record. - Ensure O2 tubing was properly dated and labeled with the last equipment change. This deficient practice could likely result in residents not getting the therapeutic results required for optimal health. The findings are: A. Record review of R #309's face sheet revealed she was admitted to the facility on [DATE] with multiple diagnoses including (not an all-inclusive list): - Acute and chronic respiratory failure with hypoxia (not enough oxygen is delivered to maintain the body's normal functions), - Hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) following cerebral infarction (stroke) affecting right dominant side, - Asthma, unspecified, - Chronic diastolic (congestive) heart failure, - Obstructive sleep apnea (a disorder in which breathing stops and starts repeatedly during sleep), - Other pulmonary embolism (a blood clot that blocks blood flow to the lungs) without acute cor pulmonale (the pulmonary embolism has not caused the right side of the heart to swell and fail). B. On 03/25/24 at 11:05 AM during an observation and interview with R #309, she sat upright in her bed with oxygen flowing through a nasal canula (a medical device that delivers supplemental oxygen to a person's nose from an attached oxygen source). The oxygen tubing and humidifier were not labeled with the date of when they were last changed. R #309 explained she required oxygen at all times due to her medical condition and was on oxygen when she was admitted to the facility. C. Record Review of R #309's medical record revealed the record did not contain a physician's orders for oxygen therapy or for changing the oxygen tubing and humidifier. D. Record Review of R #309's Treatment Administration Record (TAR), dated March 2024, revealed the record did not contain documention for staff to change or replace the resident's oxygen tubing and humidifier. E. On 03/25/24 at 11:20 AM during an interview with Nursing Provider (NP) #1, she stated staff should label the resident's oxygen tubing and humidifiers with the date of the most recent change, and R #309's was not labeled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 03/29/24 at 9:13 AM with the Director of Nursing (DON), he stated R #309 was admitted to the facility on oxygen therapy and did not have physician's orders in her chart. The DON stated the resident should have orders for both oxygen therapy and to change and date the oxygen tubing and humidifier weekly. The DON stated the facility's policy was to enter the orders for oxygen therapy and changing the oxygen tubing and humidifier at the time of admission, if a resident was admitted with oxygen. The DON stated oxygen tubing and humidifiers should always be labeled with the date of the last time it was changed.

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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** 48645 PAST NOT COMPLIANCE Based on record review and interview, the facility failed to keep a resident free from significant medication errors for 1 (R #68) of 3 (R #68, R #79, and R #7) residents randomly sampled, when they failed to administer R #68's levetiracetam (an anti-seizure medication) on the evening of 12/14/2023 and morning and evening of 12/15/2023 as per physician's order. This deficient practice resulted in R #68 having adverse side effects such as breakthrough seizures (occur when a person has a seizure after controlling their condition with medication for at least 12 months.) The findings are: A. Record review of R #68's face sheet showed the resident was admitted into the facility on [DATE] with the following diagnoses: - Traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head), - Seizures (involuntary shaking of the body), - Persistent vegetative state (chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings), - Tracheostomy [a hole surgeons make through the front of the neck and into the windpipe (trachea) so the patient can breath], - G-Tube (a tube inserted through the belly that brings nutrition directly to the stomach), - Dysphagia (difficulty swallowing). - This list of diagnosis is not all inclusive. B. Record review of R #68's physician orders, dated 12/01/23, showed an order for levetiracetam (anti-seizure medication) oral solution, 100 milligrams per milliliter (mg/ml). Give 10 ml via G-Tube (via stomach tube) two times a day for seizure disorder. C. Record review of R #68's medication administration record (MAR), dated December 2023, showed staff did not administer R #68's levetiracetam evening dose on 12/14/2023 and his morning and evening doses on 12/15/2023. D. Record review of R #68's electronic medical record (EMR) and the patient's chart revealed the following: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	1. A nursing progress note, dated 12/16/23 at 8:00 am, Notified by housekeeping and certified nursing aide (CNA) that the resident (R #68) isn't doing well. Vitals unstable, O2 (oxygen) saturation below 90 (normal blood oxygen saturation is between 100 and 90 percent), heart rate above 100 bpm (beats per minute) up to 150's (normal heart rate for males is 60 to 100 BPM). Oxygen concentrator applied up to 5 lpm (liters per minute), O2 (oxygen) saturation went up to 90. Seizure then started intermittently. Called POA (power of attorney) and called 911 right away. 2. The records did not contain information to show why staff did not administer the levetiracetam to R #68 on 12/14/23 evening and 12/15/23 morning and evening. E. Record review of R #68's hospital discharge summary, dated 12/28/2023, stated the following about R #68's condition upon admission to the emergency roiagnom on [DATE], Prior to admission, patient had 3 episodes of tonic-clonic seizures (Tonic-clonic seizures involve both tonic (stiffening) and clonic (twitching or jerking) phases of muscle activity) that lasted approximately 1 minute each per wife. Initial seizures were not witnessed, however, patient had a subsequent seizure that lasted for approximately 20 minutes which subsequently resolved after Versed (quick acting antiseizure medication) given via EMS (emergency medical services) .Per patient's wife, she was notified on 12/20/23 that patient missed 3 doses of anti-seizure medications at facility, not just one like previously thought, possibly being the cause of breakthrough seizures. F. Record review of the facility-initiated investigation regarding R #68's missed medication, dated 12/18/2023, staff provided written statements that the levetiracetam was not available in the medication cart, and that is why staff did not administer the medication as ordered. G. On 03/26/24 at 11:38 am during interview with Director of Nursing (DON), he stated staff did not administer R #68's evening dose on 12/14/2023 and his morning and evening doses on 12/15/2023, because the medication was not in the medication cart. The DON also stated the facility conducted a chart review on 12/18/2023 of R #68's change in condition and transfer to the emergency room . He said they noted R #68 appeared to have missed three doses of his levetiracetam (Keppra) medication prior to his seizures, and they initiated an investigation. The DON stated the levetiracetam was available in the facilities omnicell (fully automated, digital, medication storage and delivery machine) in tablet form, which could have been crushed and delivered via R #68's G-Tube. I. Facility initiated investigation and corrective action plan, dated 12/18/2023, revealed the following: - Persons responsible for oversight Center Executive Director (CED) and Director of Nursing (DON). - Plan was specific to: Missed medications/notification of provider. - What was done: 1. DON conducted a 7 day look back audit to determine if any other critical medications were not administered due to not being available and corrected issues as they were found. 2. DON/Designees conducted a whole-house Medication Administration Record (MAR)-to-Cart audit to ensure all ordered medications were present and available in the cart. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	3. Social Services Director (SSD) conducted interviews on the 300 hall to determine if any residents had concerns about receiving their medication. 4. Nursing Practice Educator (NPE)/Designee re-educated nurses/Certified Nursing Aides (CNAs) on the process of ordering medications timely and the escalation process (how to correct) to follow if medications were not available for administration. NPE will review the process with newly hired nurses/CNAs. 5. Nurses were re-educated on the process of ordering medications from the pharmacy timely (at least 5 days prior to running out) to ensure that medications remain available. Nurses were re-educated on the escalation process to follow if medications are not available to include accessing the Omnicell if medication is available within the Omnicell, notifying the medical provider, considering an alternative medication (within the Omnicell) with the medical provider, and calling the pharmacy to communicate urgency and request a STAT (NOW) delivery. 6. DON/designee conducted weekly audits of the process to ensure sustainability of the corrective action plan. This entailed a designated night nurse auditing and re-ordering medications for the cart once a week. Designated nurse submitted a list of re-ordered medications to the DON for auditing purposes. The DON reported progress to the QAPI (Quality Assurance and Performance Improvement) monthly for the next three months. J. Record review and verification of the corrective action was completed onsite. On 12/18/2023 the facility began auditing all residents in the building for any missed medications. Trainings, auditing, and verification started immediately after the facility identified the failed practice on 12/18/23. Trainings and education of staff were documented in the corrective action plan. The seven day look back audit was completed to identify any missed medications facility wide. No other residents were identified with this deficient practice at the time of the survey.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40671 Based on interview, record review, and observation, the facility failed to ensure staff served meals that were attractive and palatable (pleasant to taste) for 6 (R #'s 2, 7, 29, 36, 49, and 309) of 10 (R #'s 2, 7, 15, 29, 36, 37, 39, 49, 104 and 309) residents reviewed for meal quality. This deficient practice reduces residents' ability to eat and enjoy meals, may decrease their quality of life, and could likely lose weight. The findings are: A. On 03/25/24 at 11:05 AM during an interview, R #309 stated the food was not always hot and arrived to her room cold. B. On 03/25/24 at 11:15 AM during an interview, R #2 stated the food was regularly cold and unappetizing by the time it arrived to her room. C. On 03/25/24 at 11:21 am during an interview, R #29 stated the food was often unidentifiable, there was not much variety, and the food tasted awful. D. On 03/25/24 at 12:30 PM during an interview, R #49 stated she was served raw chicken on several unknown dates. She said most of the time her food was cold when staff delivered it to her room . E. On 03/25/24 at 1:26 PM during an interview, R #7 stated the food was horrible and cold most of the time. F. On 03/26/24 at 11:18 am during an interview, R #36 stated the the food was not good, and she often requested the alternative (substitute meal). The resident stated sometimes the alternative was not good either. G. On 03/27/24 at 12:37 pm observation of a randomly pulled room test tray revealed the green beans tasted unseasoned and cold; the cheese quesadilla tasted cold, and the cheese was not completely melted; the pineapple pieces and the beverage tasted warm. H. On 03/28/24 at 2:02 pm during an interview, the DM stated the residents complained to her that the food cart sat in the halls for a long time before staff delivered meals to their rooms. She stated this may be why there are complaints of cold food. 48645 49196