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	05/18/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure resident property was protected from misappropriation (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) for 1 (R #3) of 1 (R #3) resident reviewed for misappropriation of resident funds and belongings, when: R #3's purse, wallet, and reading glasses went missing in an area where a facility housekeeper was working, and only R #3's purse was eventually returned to her.If the facility fails to ensure resident property is protected from misappropriation, then residents are at risk for unauthorized use of personal funds, financial exploitation, and potential financial loss. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's follow-up incident report, dated 04/29/26, revealed that on 04/27/26, R #3 reported her pink purse missing, and staff later found it in the trash bin of the housekeeper's cart. R #3 reported her red wallet containing $20 (dollars) and her reading glasses were still missing, and the Administrator assisted her in searching her room. During the facility's review, staff learned the housekeeper had unauthorized individuals accompanying her during her shift, and she was placed on administrative leave. The housekeeper stated she accidentally discarded the purse and denied taking the missing items, although she admitted bringing unauthorized individuals into the facility. C. On 05/13/26 at 1:24 pm, during an interview, R #3 stated she always kept her purse on her nightstand, but it went missing the only time she saw the housekeeper near it. R #3 stated she had $20, business cards, and reading glasses in the purse. R #3 stated the facility found her purse, but her wallet was never located. D. On 05/14/26 at 3:01 pm, during an interview, the Registered Nurse Supervisor (RNS) stated that R #3 reported the missing belongings and money to an activities assistant, who then brought the concern to her for investigation. E. On 05/15/26 at 10:24 am, during an interview, the Medical Records (MR) stated the facility staff found R #3's purse and belongings in the housekeeper's trash bin. The MR stated the housekeeper returned the purse back to R #3, but the purse did not contain R #3's reading glasses or $20. The MR stated the facility refunded the $20 to R #3, but she was unsure about the status of R #3's wallet and reading glasses. F. On 05/18/26 at 5:38 pm, during an interview, the Activities Assistant (AA) stated she was helping in the hallway after completing meal tray service when R #3 activated her call light. R #3 reported she could not find her purse and described it as a smaller purse. Staff searched under the bed and between the sheets. R #3 reported that housekeeping had been organizing her belongings. The housekeeper stated she had cleaned R #3's room and had R #3's purse on her cart, but she had not recognized it. R #3 asked why her purse had been found in the trash can, and staff told her they were not sure. The AA stated after the housekeeper left, R #3 began looking for her wallet and located two wallets that did not belong to her, but both were empty. The AA stated R #3 could not find her red wallet or her reading glasses, and the housekeeper was accompanied by two other staff members, who were cleaning with her. The AA stated R #3 appeared panicked when her wallet and glasses were not found, so she reported this to her manager and assisted R #3 with filing a grievance. G. On 05/18/26 at 6:07 pm, during an interview, the Administrator stated that the incident involving R #3 began as a missingˆitems grievance and the housekeeper returned R #3's purse to her. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator stated that R #3's purse had been found in the trash, which she described as unusual. The Administrator stated that while staff were searching for R #3's missing belongings, the housekeeper left R #3's room and later returned with only R #3's purse. The Administrator stated that the housekeeper was terminated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff revised the care plan for 1 (R #1) of 3 (R #'s 1, 2, and 3) residents reviewed, when staff failed to: Conduct a quarterly care plan meeting as required for R #1 in accordance with their admission date and Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff).This deficient practice is likely to result in residents' care and needs not being addressed if care plan meetings are not completed as required. The findings are:A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and was discharged to the hospital on [DATE]. B. Record review of R #1's MDS page located in the electronic health record (EHR), revealed the following MDS completion dates: Dated 10/15/25, comprehensive MDS completed and submitted. Dated 01/08/26, quarterly MDS completed and submitted. Dated 04/07/26, discharge MDS completed and submitted. C. Record review of R #1's care plan meeting progress notes revealed R #1's most recent care plan meeting occurred on 11/07/25. A care plan meeting for R #1 was not documented as occurring after 11/07/25. D. On 05/13/26 at 1:50 pm, during an interview, R #1's daughter stated she had multiple care concerns regarding R #1 while she was in the facility. She reported she was unable to address these concerns with the facility because the facility did not hold care plan meetings as frequently as required. E. On 05/15/26 at 3:47 pm, during an interview, the Social Services Director (SSD) stated the facility is required to hold care plan meetings every three months. The SSD stated R #1 should have had a care plan meeting in February 2026, but the facility did not conduct one. The SSD explained that care plan meetings are important because they allow staff to meet with residents and their families to address any care concerns. F. On 05/18/26 at 6:02 pm, during an interview, the Administrator stated her expectation is for care plan meetings to occur quarterly as required by regulation. She stated R #1's care plan meetings were not conducted as required and should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) for 4 (R #'s 5, 6, 7, and 8) of 4 (R #'s 5, 6, 7, and 8) residents reviewed for ADL care provided to dependent residents, when staff failed to: Provide baths/showers per the facility bathing schedule. This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #5: A. Record review of R #5's face sheet revealed an admission date of 04/01/25 and included the following diagnoses:Need for assistance with personal care. Muscle weakness. History of falling. B. Record review of the facility's shower schedule revealed R #5's scheduled shower days are Tuesday and Friday. C. Record review of R #5's care plan, dated 02/11/26, revealed R #5 required staff assistance with ADL care due to R #5 experiencing pain and repeated falls. D. Record review of R #5's documentation survey report (ADL tracking form), dated 03/01/26 through 03/31/26, revealed R #5 was offered or provided 6 baths/showers out of 9 opportunities. E. Record review of R #5's shower sheets, dated 03/01/26 through 03/31/26, revealed R #5 was offered or provided 6 baths/showers out of 9 opportunities. F. Record review of R #5's documentation survey report, dated 04/01/26 through 04/30/26, revealed R #5 was offered or provided 4 baths/showers out of 8 opportunities. G. Record review of R #5's shower sheets, dated 04/01/26 through 04/30/26, revealed R #5 was offered or provided 3 baths/showers out of 8 opportunities. H. Record review of R #5's documentation survey report, dated 05/01/26 through 05/15/26, revealed R #5 was offered or provided 3 baths/showers out of 5 opportunities. I. Record review of R #5's shower sheets, dated 05/01/26 through 05/15/26, revealed R #5 was offered or provided 3 baths/showers out of 5 opportunities. J. On 05/13/26 at 4:56 pm, during an interview, R #5 stated he does not get offered baths or showers per the shower schedule. R #5 stated he is supposed to get at least two baths/showers per week, but he will often only get one. R #5 stated he does not feel good when he is not offered at least two showers per week. K. On 05/14/26 at 2:41 pm, during an interview, Certified Nursing Assistant (CNA) #1 stated R #5 likes to be bathed on his scheduled days. CNA #1 stated baths/showers are documented in the electronic health record and/or the shower sheets, and R #5 should be offered a bath/shower at least twice per week. R #6: L. Record review of R #6's face sheet revealed an admission date of 07/04/25 and included the following diagnoses:Need for assistance with personal care. Muscle weakness. Acquired absence of right leg below knee. M. Record review of the facility's shower schedule revealed R #6's scheduled shower days are Monday and Saturday. N. Record review of R #6's care plan, dated 01/12/26, revealed R #6 required staff assistance with mobility due to R #6 having a right leg below knee amputation. O. Record review of R #6's documentation survey report, dated 03/01/26 through 03/31/26, revealed R #6 was offered or provided 1 bath/shower out of 9 opportunities. P. Record review of R #6's shower sheets, dated 03/01/26 through 03/31/26, revealed R #6 was offered or provided 5 baths/showers out of 9 opportunities. Q. Record review of R #6's documentation survey report, dated 04/01/26 through 04/30/26, revealed R #6 was offered or provided 4 baths/showers out of 8 opportunities. R. Record review of R #6's shower sheets, dated 04/01/26 through 04/30/26, revealed R #6 was offered or provided 4 baths/showers out of 8 opportunities. S. Record review of R #6's documentation survey report, dated 05/01/26 through 05/15/26, revealed R #6 was offered or provided 1 bath/shower out of 4 opportunities. T. Record review of R #6's shower sheets, dated 05/01/26 through 05/15/26, revealed R #6 was offered or provided 3 baths/showers out of 4 opportunities. U. On 05/13/26 at 5:12 pm, during an interview, R #6 stated he is supposed to be offered a bath/shower on Monday's and Saturday's, but the shower schedule is not followed, and he will only be offered one bath/shower during the week. R #6 stated he needs the facility nursing staff's assistance with bathing, and he does not feel good when he is not offered a bath/shower per the facility shower schedule. V. On 05/14/26 at 2:43 pm, during an interview, CNA #1 stated R #6 likes at least two baths/showers per week, and staff is aware of R #6's preference. W. On 05/14/26 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 5:30 pm, during an interview, CNA #2 stated R #6 has told her that he is not offered a bath/shower per the facility shower schedule. CNA #2 stated R #6 should be offered at least two baths/showers per week. R #7: X. Record review of R #7's face sheet revealed an admission date of 03/17/26 and included the following diagnoses:Need for assistance with personal care. Reduced mobility. Muscle weakness. Y. Record review of the facility's shower schedule revealed R #7's scheduled shower days are Wednesday and Sunday. Z. Record review of R #7's care plan, dated 03/18/26, revealed R #7 required staff assistance with ADL care related to limited mobility. AA. Record review of R #7's documentation survey report, dated 03/17/26 through 03/31/26, revealed R #7's baths/showers were not documented. BB. Record review of R #7's shower sheets, dated 03/17/26 through 03/31/26, revealed R #7 was offered or provided 2 baths/showers out of 4 opportunities. CC. Record review of R #7's documentation survey report, dated 04/01/26 through 04/30/26, revealed R #7 was offered or provided 0 baths/showers out of 9 opportunities. DD. Record review of R #7's shower sheets, dated 04/01/26 through 04/30/26, revealed R #7 was offered or provided 4 baths/showers out of 9 opportunities. EE. Record review of R #7's documentation survey report, dated 05/01/26 through 05/15/26, revealed R #7 was offered or provided 3 baths/showers out of 4 opportunities. FF. Record review of R #7's shower sheets, dated 05/01/26 through 05/15/26, revealed R #7 was offered or provided 3 baths/showers out of 4 opportunities. GG. On 05/14/26 at 3:26 pm, during an interview, Nursing Assistant (NA) stated R #7 enjoys baths/showers and R #7 should be offered at least two baths/showers per week as scheduled. HH. On 05/18/26 at 4:24 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated R #7 does not refuse baths/showers and R #7 should be offered at least two baths/showers per week as scheduled. II. On 05/18/26 at 4:34 pm, during an interview, R #7 stated she has missed showers often and it makes her feel like shit when she is not offered or given baths/showers per the facility shower schedule. R #8: JJ. Record review of R #8's face sheet revealed an admission date of 06/05/25 and included the following diagnoses:Thoracic spinal cord injury (damage occurring to the spinal cord in the chest region, specifically between the vertebrae T1 and T12). Need for assistance with personal care. Reduced mobility. Muscle weakness. KK. Record review of the facility's shower schedule revealed R #8's scheduled shower days are Monday and Friday. LL. Record review of R #8's care plan, dated 03/12/26, revealed R #8 required staff assistance with ADL care related to paralysis (the loss of the ability to move, and sometimes to feel anything, in part or most of the body) and weakness. MM. Record review of R #8's documentation survey report, dated 03/01/26 through 03/31/26, revealed R #8 was offered or provided 5 baths/showers out of 9 opportunities. NN. Record review of R #8's shower sheets, dated 03/01/26 through 03/31/26, revealed R #8 was offered or provided 5 baths/showers out of 9 opportunities. OO. Record review of R #8's documentation survey report, dated 04/01/26 through 04/30/26, revealed R #8 was offered or provided 6 baths/showers out of 8 opportunities. PP. Record review of R #8's shower sheets, dated 04/01/26 through 04/30/26, revealed R #8 was offered or provided 5 baths/showers out of 8 opportunities. QQ. Record review of R #8's documentation survey report, dated 05/01/26 through 05/15/26, revealed R #8 was offered or provided 3 baths/showers out of 5 opportunities. RR. Record review of R #8's shower sheets, dated 05/01/26 through 05/15/26, revealed R #8 was offered or provided 4 baths/showers out of 5 opportunities. SS. On 05/14/26 at 2:35 pm, during an interview, CNA #1 stated R #8 wants two to three baths/showers per week and does not refuse baths/showers often. TT. On 05/14/26 at 3:55 pm, during an interview, R #8 stated she received a shower yesterday (05/13/26) for the first time in almost a week. R #8 stated she needs help with baths/showers and when she is not offered baths/showers per the facility shower schedule, she does not feel like herself and she does not want to be around others. UU. On 05/14/26 at 5:29 pm, during an interview, CNA #2 stated R #8's baths/showers are often missed or forgotten. CNA #2 stated she has seen R #8 cry after missing baths/showers while stating nobody wants to help her. VV. On 05/18/26 at 5:22 pm, during an interview, the Director of Nursing (DON) stated all residents in the facility should be offered a bath/shower per the facility shower schedule. The DON (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated R #5, #6, #7, and #8 were not offered enough baths/showers per the facility shower schedule and her expectations but should have been.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all 89 residents residing in the facility, when:The facility failed to offer baths or showers to residents as scheduled. The facility staff used R #4's family member to assist with a transfer using a Hoyer lift (equipment used to move residents who have limited mobility) when staff were not available. These deficient practices are likely to negatively impact resident safety, comfort, and impede processes such as timely showers and appropriate assistance with care. The findings are:Baths/Showers: A. Refer to F0677 for related findings. B. On 05/13/26 at 4:56 pm, during an interview, R #5 stated the facility is so shortˆstaffed that staff often do not offer or provide him with at least two baths or showers per week. R #5 stated nursing staff tell him they do not have enough staff to complete his showers consistently. C. On 05/13/26 at 5:12 pm, during an interview, R #6 stated Certified Nursing Assistants (CNAs) often tell him they do not have enough help, and as a result, he regularly misses a bath or shower. D. On 05/14/26 at 2:42 pm, during an interview, CNA #1 stated she ensures her residents receive their scheduled baths or showers, but she knows other residents miss their baths or showers due to low staffing. CNA #1 stated resident baths and showers can take between 15 and 45 minutes, which affects staffing on the unit floors. E. On 05/14/26 at 3:55 pm, during an interview, R #8 stated there are often times when the facility does not have enough CNAs, and as a result, her baths or showers are missed. F. On 05/14/26 at 5:27 pm, during an interview, CNA #2 stated the facility does not have enough staff, and when the facility is shortˆstaffed, residents' baths and showers are often missed. CNA #2 stated residents do not receive the help they need when there is not enough staff, which occurs often. G. On 05/18/26 at 4:34 pm, during an interview, R #7 stated that on several occasions the facility nursing staff has told her they did not have enough staff to bathe her according to the facility's schedule. R #7 stated she often misses showers on the weekends. H. On 05/18/26 at 4:44 pm, during an interview, Licensed Practical Nurse (LPN) #2 stated the facility is shortˆstaffed with both CNAs and nurses. LPN #2 stated residents should be offered at least two baths or showers per week, but this does not occur because there is not enough nursing staff available. I. On 05/18/26 at 4:56 pm, during an interview, LPN #3 stated the facility consistently has staffing issues, which affects the care residents receive. LPN #3 stated residents' baths and showers are often missed due to the lack of nursing staff. J. On 05/18/26 at 5:19 pm, during an interview, the Director of Nursing (DON) stated it is her expectation that nursing staff offer baths and showers according to the facility's shower schedule. Hoyer Lift: K. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: Morbid (severe) obesity due to excess calories. Muscle weakness. Need for assistance with personal care. Traumatic brain injury (TBI). L. Record review of R #4's physical therapy treatment encounter note, dated 11/19/25, revealed R #4's mother was instructed on the proper use of the Hoyer lift for safe transfers. They were reminded that the Hoyer lift requires two persons during all transfers to ensure safety and reduce risk of injury. M. Record review of R #4's care plan, dated 05/06/26, reveled the following: R #4 is a long-term care resident and does not have current plans to discharge. R #4 is at risk for falls related to impaired mobility and a TBI. R #4 requires assistance from two staff for Hoyer lift transfers. R #4's care plan did not indicate that R #4's family could assist with transfers instead of facility nursing staff. N. On 05/13/26 at 4:39 pm, during an observation, CNA #4 brought a Hoyer lift into R #4's room alone. R #4 was seated in a wheelchair next to her bed with family present. CNA #4 closed the door after entering. O. On 05/13/26 at 4:48 pm, during an observation and interview, CNA #4 was observed leaving R #4's room, and R #4 was lying in bed. CNA #4 stated she did not usually work on the unit where R #4 resides, but she had been asked to assist R #4. CNA #4 stated R #4 requires a twoˆperson assist for transfers, but there was not any (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other staff available to help her, so she asked R #4's mother to assist. CNA #4 stated she only asked R #4's mother to help because there was not any other staff available. P. On 05/13/26 at 4:52 pm, during an interview, R #4 stated there is not enough staff to transfer her when needed. R #4 stated she has to wait extended periods of time to be transferred due to the facility's staffing issues. Q. On 05/14/26 at 2:37 pm, during an interview, CNA #1 stated she was not aware of any family member in the facility who was trained to assist with resident transfers. CNA #1 stated she had been informed that only two trained staff members should transfer a resident using a Hoyer lift. R. On 05/14/26 at 3:01 pm, during an interview, the Registered Nurse Supervisor (RNS) stated she was not aware of any family member in the facility who was trained to assist with resident transfers, and that Hoyer lift transfers should only be performed by two trained staff members. S. On 05/14/26 at 3:26 pm, during an interview, Nursing Assistant (NA) #1 stated she was taught that only two trained staff members are permitted to transfer a resident using a Hoyer lift. NA #1 stated facility staff should not ask family members to assist with resident transfers. T. On 05/14/26 at 5:31 pm, during an interview, CNA #2 stated that even though the facility experiences short staffing, only trained staff members should transfer a resident, not family members. U. On 05/15/26 at 10:34 am, during an interview, the Director of Rehab (DOR) stated R #4 is always with her mother or grandmother. The DOR stated R #4's mother was educated on the Hoyer lift because R #4 was expected to be discharged home with Hoyer lift use, but the discharge did not occur. The DOR stated the training provided to R #4's mother on 11/19/25, but it was not intended to replace staff assistance while R #4 remained in the facility. V. On 05/15/26 at 10:43 am, during an interview, Physical Therapy Assistant (PTA) stated R #4 was expected to discharge home, and the training was completed with R #4's mother so she could assist a paid caregiver at home. The PTA stated the training provided to R #4's mother was basic and not as inˆdepth as the training facility staff receive. W. On 05/18/26 at 4:24 pm, during an interview, LPN #1 stated that even when staff are not available, a resident's family member should not assist with Hoyer lift transfers. X. On 05/18/26 at 5:25 pm, during an interview, the DON stated nursing staff should be available to assist residents, but she was okay with family members assisting with Hoyer lift transfers only if the family members were properly trained.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Cross-Reference with F0602. Based on record review and interviews, it was determined the facility was not administered in a manner that ensured the effective and efficient use of resources to attain or maintain each resident's highest practicable physical, mental, and psychosocial well^being, when:The facility administration failed to prevent unauthorized individuals, who were not contracted or directly hired by the facility, from working in the facility near residents.This deficient practice is likely to affect the 89 residents listed on the facility census provided by the Administrator on 05/13/26. If the facility is unaware of an individuals' status when they enter the facility and are near residents, residents' safety and well^being are placed at risk. The finds are: A. Record review of R #3's facility follow-up incident report, dated 04/29/26, revealed when the facility was reviewing R #3's missing item grievance, the night nurse manager reported that the housekeeper in question had two men accompanying her, which the nurse manager found unusual. The nurse manager stated that all three individuals were wearing uniforms, and the housekeeper told her that she was training the two men. The Administrator contacted the housekeeping supervisor and learned that this was not true; the men accompanying the housekeeper were not employees and were not authorized to be in the facility. The housekeeper was placed on administrative leave, and the unidentified individuals were directed to leave the facility. The housekeeper admitted that she had allowed unauthorized individuals to accompany her during her shift. She reported that her boyfriend and brother^in^law had been helping her but claimed they had never been alone and always remained with her. She stated that neither man took R #3's wallet. The housekeeper also admitted she dressed the two men in work uniforms and told others she was training them because she did not want them to get in trouble for being in the facility. Interviews with other residents confirmed no additional concerns related to the housekeeping staff or the security of personal belongings, and no pattern of grievances related to missing valuables was identified. B. On 05/14/26 at 3:07 pm, during an interview, the Registered Nurse Supervisor (RNS) stated that during the facility's investigation of R #3's missing^items grievance, staff discovered the two men accompanying the housekeeper were not hired or contracted facility staff. The RNS stated the housekeeper claimed she was training them, but this was not accurate, and the individuals should not have been in the facility impersonating facility staff. The RNS stated they were unaware this was occurring and did not know how long the two individuals had been accompanying the housekeeper into the facility. C. On 05/18/26 at 5:22 pm, during an interview, the Director of Nursing (DON) stated the facility staff located the two individuals who had been accompanying the housekeeper and escorted them out of the facility. The DON stated the housekeeper reported she had dressed her boyfriend and brother^in^law as housekeeping staff to help her, even though they were not hired or contracted by the facility. The DON stated she was unaware this was occurring and unauthorized individuals should not be in the facility near residents. D. On 05/18/26 at 6:10 pm, during an interview, the Administrator stated she immediately reached out to the housekeeping supervisor who informed her that they had not recently hired new staff members. The Administrator stated she interviewed the housekeeper, and the housekeeper admitted that she had dressed her boyfriend and brother-in-law in housekeeping attire to help her, but those two individuals were not hired or contracted by the facility. The Administrator stated the housekeeper was terminated and unauthorized individuals should not be in the facility near residents.