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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 49196 Based on observation, interview, and record review, the facility failed to ensure that Minimum Data Set (MDS; a federally mandated standardized assessment tool completed by facility staff, that measures health status in nursing home residents) assessments included accurate insulin use information for 2 (R #2 and R #3) of 2 (R #2 and R #3) residents reviewed for MDS accuracy. This deficient practice could likely result in residents not receiving the most optimal and personalized care required to meet their highest practicable outcomes. The findings are: R #2 A. Record review of R #2's quarterly MDS assessment, dated 01/19/2024, Section N, indicated R #2 received seven insulin injections during the seven day look back period (The time period over which staff observe a resident to capture the resident's condition or status for the MDS assessment. Unless otherwise stated, the look back period is seven days, and only those occurrences during the look back period will be captured on the MDS.) B. Record Review of R #2's physician's order summary, dated January 2024, did not include an order for the administration of insulin. C. Record review of R #2's Medication Administration Record (MAR), dated January 2024, revealed staff did not administer insulin to R #2. R #3 D. Record Review of R #3's quarterly MDS assessment, dated 02/01/2024, Section N, indicated R #3 received seven insulin injections during the seven day look back period. E. Record Review of R #3's physician's orders, dated January 2024, did not include an order for the administration of insulin. F. Record review of R #3's MAR, dated January 2024, revealed staff did not administer insulin to R #3. G. On 03/28/24 at 9:38 AM during an interview with the MDS nurse, she confirmed neither resident had an order for the administration of insulin during the look back period. She said staff should not have indicated that on the MDS assessment.

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 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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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on observation and interview, the facility failed to properly store medications in medication carts by allowing loose medications under the medication cards (cards that contain individually sealed tablets in which the medication must be pushed through the foil in order to take the medication). This deficient practice has the likelihood to result in all residents on hall 300 and 400, as identified on the census list provided by the administrator on [DATE], to receive expired or improperly temperature-controlled medications that have either lost their potency or effectiveness. The findings are: A. On [DATE] at 8:33 am, during an observation of the 400 hall medication cart, a loose round, white tablet lay under the medication cards. B. On [DATE] at 8:44 am, during observation of the 300 hall medication cart, loose medications lay under the medication cards. The loose medications included one white oval tablet, two pink oval tablets, one liquid capsule, and two white circular tablets. C. On [DATE] at 10:22 am, during an interview with the Director of Nursing (DON), he stated loose medications are not allowed to be stored in the medication carts and staff should check for loose medications daily.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40671 *This is a repeat deficiency. Based on interview, observation, and record review, the facility failed to serve food according to the presented menu. This deficient practice has the potential to affect all 116 residents listed on the census presented by the Administrator (ADM) on 03/25/24 and could likely result in resident frustration and/or dissatisfaction with meal options and therefore residents' may not receive required nutrition to maintain their best health. A. On 03/26/24 at 9:42 am during an interview, R #37 stated there was not much variety, and the menu was not followed. R#99 B. Record review of posted lunch menu for 03/27/24 revealed staff to serve the following for lunch: Country fried steak with mushroom gravy or fish tacos with flour tortilla, dinner roll, pineapple tidbits, seasoned potato wedges, and seasoned green beans or Mexican street corn. C. On 03/27/24 at 11:57 am during a random meal observation, staff served R #99 a plate of Salisbury steak, mashed potatoes with brown gravy, and a small bowl of salad. Staff did not serve the resident the items on the posted lunch menu. D. Record Review of R #99's lunch meal ticket, dated 03/27/24, revealed staff to serve R #99 a plate of Salisbury steak, mashed potatoes with brown gravy, and a small bowl of salad. R #49 E. On 03/27/24 at 1:25 pm during a random meal observation and interview with R #49, staff served R#49 a plate of Salisbury steak, mashed potatoes with brown gravy, and a small bowl of salad. R #49 stated she was vegetarian and did not eat meat. F. Record review of R #49's lunch meal ticket, dated 03/27/24, revealed staff to serve the resident a cheese quesadilla, seasoned green beans, and pineapple tidbits. G. Record review of Diet Order and Communication form for R #49, dated 06/25/19, revealed the resident's preference was vegetarian diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 03/28/24 at 2:02 pm during an interview, the Dietary Manager (DM) stated sometimes the providers are out of stock when they place their food order so they have to make substitutions. She stated that this happened one to two times per month. She stated substitutions are identified on the daily menu. The DM stated when the menu changes, they serve the posted substitute menu. She was not sure why some residents were able to order the Salisbury steak but verified that the Chicken fried steak or fish tacos was supposed to be for this date's menu. The DM stated she was not aware R #49 was vegetarian. She stated the Certified Nursing Assistant (CNA) did not specify to the cook if it was a regular tray or the cheese quesadilla when he requested a tray for R #49.

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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

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40671 *This is a repeat deficiency. Based on observation, record review, and interview, the facility failed to take into consideration food preferences (choices) for 2 (R #36 and R #49) of 2 (R #36 and R #49) residents by not providing an alternative meal substitution as per resident request. This deficient practice could likely affect all 116 residents identified on the facility census provided by the Administrator (ADM) on 03/25/24 and could likely result in residents feeling frustrated that staff do not support their rights and choices. The findings are: Resident #36 A. Record review of posted lunch menu for 03/27/24 revealed staff to serve the following for lunch: Country fried steak with mushroom gravy or fish tacos with flour tortilla, dinner roll, pineapple tidbits, seasoned potato wedges, and seasoned green beans or Mexican street corn. B. Record review of Available Daily Lunch and Dinner Menu revealed the following items were available: Grilled cheese sandwich; peanut butter and jelly sandwich; ham and cheese sandwich; chef salad with vinaigrette (a type of salad dressing); and cheese quesadilla. C. On 03/26/24 at 11:52 am during an interview with R #36, she stated she turned in her order sheet every day, and they always mess up her order so she just orders the cheese quesadilla. D. On 03/27/24 at 11:57 am during an interview and observation, R #36 was frustrated, upset, and stated what she was served was not what she ordered. R #36 was served a plate with a chicken fried steak, mashed potatoes and green beans. R #36 pointed to another resident's plate, who was seated at the same table, and stated she (R #36) ordered the Salisbury steak like the other resident. Staff told R #36 that they ran out of the Salisbury steaks. Resident was visibly upset and began to cry. Observation of R #36's order sheet, dated 03/27/24, revealed staff did not serve R #36 the meal she selected for lunch. The resident ordered the following: For lunch - steak, for dinner - chicken. E. On 03/27/24 at 1:25 pm during an interview the Dietary Manager (DM) stated that R #36 regularly requests the alternative menu item, and usually orders the cheese quesadilla. She stated that the reason R #36 did not receive a Salisbury steak was because the kitchen ran out of them. She stated that she was not sure why some residents received Salisbury steak today when the menu stated chicken fried steaks was the day's lunch. Resident #49 E. On 03/27/24 at 1:25 pm during an observation and interview, staff delivered a meal tray to R #49's room which consisted of a small bowl of salad, a Salisbury steak, mashed potatoes with brown gravy, a pre-packaged cookie, and a cup of pink beverage. R #49 stated she did not eat meat, because she was a vegetarian. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of Diet Order and Communication form for R #49, dated 06/25/19, revealed the resident's preference was vegetarian diet. G. On 03/28/24 at 2:02 pm during an interview with the Dietary Manager (DM), she stated she was not aware R #49 was vegetarian. She stated R #49 usually ordered a cheese quesadilla for both lunch and dinner. She further stated the Certified Nursing Assistant (CNA) did not specify to the cook if it was a regular tray or the cheese quesadilla when he requested a tray for R #49.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40671 Based on observation and interview record review, the facility failed to serve food under sanitary conditions in accordance with professional standards of food service safety when staff failed to monitor the internal temperature of food to ensure it is safe for consumption. This deficient practice is likely to result in residents getting a food borne illness and could likely affect all 115 residents identified on the census list provided by the Administrator on 02/12/24. The findings are: A. On 03/25/24 at 10:58 AM during an interview, R #39 stated his food was always served cold. B. 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. C. 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. D. On 03/25/24 at 12:30 PM during an interview with R #49, she said she was served raw chicken on several unknown dates. She said most of the time when her food was delivered to her room it was cold. E. On 03/25/24 at 1:26 PM during an interview with R #7, she stated the food was horrible and cold most of the time. H. On 03/28/24 at 8:57 AM during an interview with R #49, she stated breakfast was cold when it was delivered to her room. I. Record Review of the U.S. Food and Drug Administration (FDA) Food Code, 2022 edition, revealed staff should serve cold foods at an internal temperature of 41 degrees ( ) Fahrenheit (F) or lower and hot foods at 135 F or higher. J. On 03/27/24 at 12:35 PM during a random room tray observation and interview with the Dietary Manager (DM), the following temperatures were taken and verified by the Dietary Manager (DM): 1. Cheese quesadilla (hot food) measured 101.9 F . 2. Seasoned potato wedges (hot food) measured 96.0 F. 3. Pineapple tidbits (cold food) measured 60.5 F. 4. Cup of lemonade/juice (cold food) measured 49.8 F. DM stated that the pineapple tidbits were reading colder earlier and wasn't sure why they were reading warmer now. She verified that hot foods should be served hot and cold foods should be served cold unless a resident requests otherwise. (continued on next page)

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	K. On 03/28/24 at 11:27 AM during a random observation of lunch meal, the following steam table temperatures were taken by and verified by the DM: 1. Egg salad sandwiches (cold food) measured 44.5 F. 2. Italian sub sandwiches (cold food) measured 50.3 F. L. 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 that this may be why there was cold food. 48645 49196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 49196 Based on observation, interview, and record review, the facility failed to ensure a resident's call light was functioning as intended for 1 (R #3) of 1 (R #3) resident reviewed for call system functioning. This deficient practice could likely result in residents being unable to notify staff when they are in need of assistance. The findings are: A. On 03/25/24 at 1:48 PM during an observation, R #3 was in her bed with a bed side commode (BSC) next to her bed. A call light button was attached to the BSC. B. On 03/25/24 at 1:50 PM during an interview, R #3 stated her call light did not work and has not worked for several days. She added she notified multiple staff members, and nothing has been done about it. C. On 03/25/24 at 1:52 PM, during an observation, R #3 pressed the call light button two separate times. The hallway indicator light did not activate on either attempt. D. Record review of facility's maintenance work orders revealed the record did not contain an open or resolved work order for R #3's call light. E. On 03/27/24 at 1:00 PM, the Administrator stated R #3's call light was in need of repair on 03/25/24, and there was not a work order entered. She stated she expected staff to notify the maintenance department of a non-funcitoning call light as soon as it was reported by the resident.