STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325036	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Palomas Center	8100 Palomas Avenue 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation and interview, the facility failed to ensure residents were treated with respect and dignity for 1(R #1) of 1 (R #1) resident when the facility failed to ensure the resident was not soiled while in the common areas for extended periods of time. This deficient practice is likely to result in residents feeling as if they were unimportant and not having privacy. The findings are: A. On 08/25/25 at 10:00 am observation revealed R #1 seated in her wheelchair visibly wet from her lower shirt to knees, located at the south nursing station. Further observation revealed R #1 remained soiled in the common area for 15 minutes. B. On 08/25/25 at 10:15 am during an interview with R #1, she stated they do not care, I have to wear two briefs because the other ones do not hold enough, and they will not change me unless I ask.C. On 08/25/25 at 10:15 am during an interview with Certified Nursing Assistant (CNA) #4, he stated he would just take care of it, after R #1 asked him who was her assigned CNA. He stated he could see R #1 was wet. D. On 08/26/25 at 2:10 pm during an interview with R #1's Power of Attorney (POA), she stated the bathing schedule seems off, and R #1 always complains to me about not being clean, staff need to be more aware of her. She also stated she took R #1 to a Urologist (A doctor who specializes in diagnosing and treating problems of the urinary tract), and they did not see a reason for the incontinence (Loss of control over urination or bowel movements), so R #1 previously had a foley catheter (a thin plastic tube used for continuous urine drainage) placed but it was removed three months ago.E. On 08/29/25 at 12:40 pm observation revealed the following:R #1 was located in the dining room after lunch service while seated in her wheelchair.Resident had a strong odor of urine. F. On 08/29/25 at 2:00 pm observation revealed R#1 was still wet with urine after she traveled the hallways between the dining room and the south nursing station common areas. R #1 self-propelled in her wheelchair past Licensed Practical Nurse (LPN) # 4 and the Nurse Practice Educator (NPE) on the two hallways to the south nursing station. R #1 then asked the NPE to assist with calling her POA at the nurse's station phone. The NPE pushed R # 1's wheelchair to the phone from the west hallway to the south nurse's station and after four minutes of unsuccessful phone call attempts, the NPE took R #1 to the Social Services office to use the phone. R #1 spoke with the POA and then asked The NPE to assist with a brief change, and the NPE asked CNA #8 to change the resident's brief.G. On 09/02/25 at 3:15 pm during an interview with CNA #11, he stated to ensure resident's dignity while incontinent he monitors each incontinent resident continually. He stated I make sure they're clothed and clean, covered up if necessary. Only a few residents need monitoring, but staff are familiar with those who need extra support. CNA #11 stated if he saw a resident soiled in the hallway or common areas he would address it even if it wasn't his assignment. He stated anyone with a clinical certification should be able to help change a brief.H. On 09/02/2025 at 4:30 pm observation revealed R #1 had a foley catheter placed after an appointment with the Urologist on 09/02/25 at 2:00 pm.I. On 09/02/25 at 4:30 pm during an interview with R #1, she stated she requested for a foley catheter to be reinserted at the Urologist today due to not being changed often enough. She stated the POA had to purchase a new outfit for her since she was soiled upon arrival at the Dr.'s office, which included a bowel movement. R #1 stated through clenched jaws that she was embarrassed at the office and just feels wet when she is not changed and wearing clean clothes.J. On 09/03/25 at 9:30 am during an interview with the Director of nursing (DON) she stated the expectation for facility staff to ensure the dignity of incontinence residents, is staff completes rounding but they cannot force residents to get cleaned, sometimes they will refuse when we ask them to receive 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to properly intervene and prevent a Certified Nurse's Aide (CNA) from touching and interacting inappropriately with multiple residents over multiple times for 4 (R #17, 46, 96, and 120) of 4 (R #17, 46, 96, and 120) residents who were reviewed for possible abuse. If staff do intervene and take steps to prevent abuse, then other residents are at risk of abuse which may cause physical, emotional, and psychological harm. The findings are: R #96A. Record review of R #96's face sheet, dated 09/04/25, revealed an admission date of 09/07/24 with the following diagnoses: Cerebral (brain) Infarction (stroke),Monoplegia (paralysis of one limb) of lower limb left side,Dysphagia (difficulty swallowing), Dysphonia (difficulty speaking). B. Record review of R #96's Minimum Data Set (MDS; a collection of assessments of a resident's abilities and care needs), dated 06/27/25, revealed a Brief Interview of Mental Status (BIMS; a simple test of mental/Memory abilities) score of 13, cognitively intact. C. Record review of R #96's daily care notes, dated 08/06/25 at 1:49 pm and entered by Social Services Director (SSD) revealed the SSD was informed of a report of sexual abuse from a night CNA. R #96 told the SSD, When he was putting cream on my private parts, I felt him put his finger up there [anus]. The SSD reported the incident to the facility Administrator (ADM) and the facility Abuse Officer. D. Record review of the facility's provided Incident Report, dated 08/13/25, revealed R #96 stated CNA #1 performed peri care (care provided to maintain cleanliness at the area of the body between the genitals and anus) on 08/06/25. During peri care, R #96 reported CNA #1 touched her anus (the opening at the end of the large intestine where waste is excreted) with his finger. R #96 stated the interaction made her feel uncomfortable. R #96 stated she felt the touching was intentional. The report indicated CNA #1 was placed on leave on the morning of 08/06/25, pending the outcome of the investigation. The report stated an abuse questionnaire was conducted with other residents in the facility. Per the report, the abuse questionnaire did not reveal any abuse of other residents. Staff were educated to inform residents of their actions while providing care. CNA #1 was allowed to return to work on 08/06/25 for his next scheduled shift at 6:00 pm, with the requirement that he did not have further contact with R #96. E. On 08/26/25 at 3:30 pm during interview, R #96 stated CNA #1 tried to hug her on multiple occasions (she could not recall specific dates). R #96 stated CNA #1 used inappropriate language with her on several occasions, but she could not provide the specific statements. She stated she felt the communication was inappropriate. R #96 stated CNA #1 touched her anus while conducting peri care on one occasion (08/06/25). R #96 reported the incident to the Social Services Assistant (SSA). R #96 stated she became very uncomfortable with CNA #1 assisting her, and she asked that CNA #1 not be assigned to her again. R #96 stated CNA #1 was moved to another area since her complaint, and she did not receive care from him again. R #46F. Record review of R #46's face sheet dated 09/08/25 revealed she had been admitted to the facility on [DATE] with multiple diagnoses including:Acute cystitis (sudden onset inflammation of the bladder),Heart failure (a condition when the heart fails to efficiently pump blood). G. Record review of R #46's MDS, dated [DATE], revealed a BIMS score of 12, cognitively intact. H. Record review of R #46's daily nursing note, dated 08/21/25 at 11:38 am and written by the Social Services Assistant (SSA), stated, This writer received report that resident [R #46] claimed her night CNA attempted to sexually abuse her. When resident was interviewed, she stated, 'I kicked him away and told him I am not that pendeja (asshole) cabron! (bastard) I am going to report you. CNA then stated, 'I don't give a fuck. He turned off all the lights and used the light on his phone to see. He put his hand under [R #120; roommate] blanket, and I heard him say 'Do you like that?' This writer [SSA] and SSD performed abuse questionnaires on whole building and filed police report on accused CNA [not identified]. I. Record review of R #46's daily nursing note, dated 08/22/25 at 8:54 am, revealed a change of condition in which R #46 reported the night shift CNA (CNA #1) engaged in sexual harassment toward both her and her roommate R #120. J. On 08/25/25 at 1:00 pm during phone interview, R #46 stated CNA #1 entered her room during the early morning hours of 08/21/25, and CNA #1 attempted to touch her body. R #46 stated she became angry and yelled at him. R #46 stated CNA #1 left her and went to her roommate (R #120). R #46 stated she could see CNA #1 as he placed his hand under R #120's blanket and touched her body. R #46 stated she could hear CNA #1 ask R #120 if she liked what he was doing. R #46 could not hear any response from R #120. R #120K. Record review of R #120's face sheet dated 08/25/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: Wernicke's encephalopathy (a serious brain disorder associated with alcohol abuse and

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 thoroughly investigate multiple allegations of abuse. The facility then failed to take steps to prevent any future abuse of 4 (R #17, 46, 96 and 120) out of 4 (R #17, 46, 96 and 120) residents reviewed for abuse. If staff do not investigate allegations of abuse and take steps to prevent abuse, then other residents are at risk of abuse which may cause physical, emotional, and psychological harm. The findings are:R #96 A. Record review of R #96 face sheet, dated 09/04/25, revealed she had been admitted to the facility on [DATE] with multiple diagnoses including: -Cerebral (brain) Infarction (stroke), -Monoplegia (paralysis of one limb) of lower limb left side, -Dysphagia (difficulty swallowing), -Dysphonia (difficulty speaking). B. Record review of R #96's Minimum Data Set (MDS; a collection of assessments of a resident's abilities and care needs) Brief Interview of Mental Status (BIMS; a simple test of mental/memory abilities), dated 06/27/25, revealed a score of 13, cognitively intact. C. Record review of a facility provided Incident Report number 2584078, dated 08/13/25, revealed a report by R #96 in which she accused Certified Nurse's Aide (CNA) #1 of performing pericare (care provided to maintain cleanliness at the area of the body between the genitals and anus) on 08/06/25. During pericare, R #96 reported CNA #1 touched her anus with his finger. The report indicated CNA #1 was placed on leave pending the outcome of the investigation. The report further stated an abuse questionnaire was conducted with other residents in the facility. Per the report, the abuse questionnaire revealed no other abuse of other residents. Staff were educated to inform residents of their actions while providing care. CNA #1 was allowed to return provided he had no further contact with R #96. D. Record review of R #96's daily care notes, dated 08/06/25 at 1:49 pm and entered by the Social Services Director (SSD), revealed she was informed of a report of sexual abuse from a night CNA. The SSD was told by R #96, When he was putting cream on my private parts, I felt him put his finger up there [anus]. The SSD reported the incident to the facility Administrator (the facility Abuse Officer). E. On 08/26/25 at 3:30 pm during an interview with R #96, she stated CNA #1 had tried to hug her on 08/08/25 on multiple occasions. She stated CNA #1 used inappropriate language with her on other occasions, and CNA #1 touched her anus while conducting pericare on another occasion. R #96 reported these multiple events made her feel very uncomfortable and caused her to ask that CNA #1 not be allowed to provide care to her. R #46 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F. Record review of R #46's face sheet, dated 09/08/25, revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Acute cystitis (sudden onset inflammation of the bladder), -Heart failure. G. Record review of R #46's MDS BIMS, dated 08/09/25, revealed a score of 12, moderately impaired. H. Record review of R #46's daily nursing notes revealed the following: - Dated 08/21/25 at 11:38 am and written by Social Services Assistant (SSA), stated, This writer received report that resident [R #46] claimed her night CNA attempted to sexually abuse her. When resident was interviewed, she stated 'I kicked him away and told him I am not that pendeja [asshole] cabron [bastard]! I am going to report you. CNA then stated, 'I don't give a fuck. He turned off all the lights and used the light on his phone to see. He put his hand under her [R #120's] blanket, and I heard him say 'Do you like that?' This writer (SSA) and SSD performed abuse questionnaires on whole building and filed police report on accused CNA. - Dated 08/22/25 at 8:54 am, revealed a change of condition in which R #46 reported the night shift CNA (CNA #1) had engaged in sexual harassment toward both her and her roommate R #120. I. On 08/25/25 at 1:00 pm during a phone interview with R #46, she stated CNA #1 entered her room during the early morning hours of 08/21/25, and CNA #1 attempted to touch her body. R #46 stated she became angry and began to yell at him. R #46 stated CNA #1 then left her and went to her roommate (R #120). R #46 stated she could see CNA #1 as he placed his hand under R #120's blanket and touched her body. R #46 stated she could hear CNA #1 as he asked R #120 if she liked what he was doing to her. R #120 J. Record review of R #120's face sheet, dated 08/25/24, revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Wernicke's encephalopathy (a serious brain disorder associated with alcohol abuse and malnutrition with symptoms of confusion), -Cognitive communication deficit (difficulty understanding words and communicating with others), -Adult sexual abuse confirmed. K. Record review R #120's MDS BIMS, dated 08/25/25, revealed a score of 9, moderately impaired. L. Record review of R #120's daily nursing notes revealed the following: - Dated 08/22/25 at 1:05 am, R #120 was found on the floor of her room. She was confused, fearful, and talked about an event she believed had happened. R #120 reported she was afraid of someone. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Dated 08/22/25 at 2:28 am, a change of condition for behavioral symptoms-agitation, psychosis (a condition of the mind causing illogical and irrational thoughts). R #120 seemed different than usual. - Dated 08/22/25 at 6:33 am, police arrived after a resident (unknown) called 911. Police spoke with R #120, then with the night staff, and then left the facility. - Dated 08/22/25 at 2:25 pm, a note by SSD that a Sexual Assault Nurse Examiner (SANE) nurse arrived at 2:13 pm to evaluate and treat resident for sexual assault. (No results of the SANE exam were available). M. On 08/25/25 at 11:00 am during an interview with R #120, she was unable to recall any events during her stay at the facility. She was unable to recall any care provided by CNA #1. She was unable to recall CNA #1. Throughout the interview, R #120 seemed fearful and confused. N. On 08/25/25 at 11:20 am during a phone interview with R #120's husband, he stated the facility staff informed him that his wife had been assaulted by a CNA working with his wife during the night on 08/21/25 to 08/22/25. The husband stated he was not told of any details of his wife's assault. The husband stated he came to the facility late in the afternoon to be with his wife. He stated that when he arrived, his wife began crying and apologizing for cheating. The husband stated he tried to reassure his wife that she was not to blame. The husband stated that his wife was becoming more confused since her admission to the facility. R #17 O. Record review of R #17's face sheet, dated 09/04/25, revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Sepsis (a several general infection), -Urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra), -Low back pain. P. Record review of R #17's MDS BIMS, dated 08/18/25, revealed a score of 14, cognitively intact. Q. Record review of R #17's daily nursing notes revealed staff did not document any complaints from R #17 regarding care from CNA #1 or any other staff member. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R. On 08/26/25 at 1:30 pm during an interview, R #17 stated she was assisted on multiple occasions by CNA #1 with general daily care such as repositioning, transferring from bed to wheelchair, and peri-care. R #17 stated CNA #1 would make inappropriate comments such as Will you miss me? and Do you think of me? R #17 stated she found these comments to be creepy, and she felt CNA #1 was trying to groom her. She denied CNA #1 attempted to touch her inappropriately. R #17 could not provide specific dates or times when these comments occurred. R #17 stated she never reported any of this information to any staff. She stated she did not like his care. She stated CNA #1 was a night shift worker, and he had less contact with her on a day-to-day basis. She stated that is why she did not make any complaints. S. On 08/27/25 at 11:00 am during an interview, the Administrator stated CNA #1 was an agency CNA (an employee who works by contract through another agency). The Administrator stated he was informed of the allegations made by R #96 on 08/06/25 regarding CNA #1, and he immediately began an investigation of abuse. The Administrator stated CNA #1 worked the night shift ending 08/06/25, and CNA #1 was assigned to give care to R #96 on the night shift ending 08/06/25. The Administrator stated CNA #1 was scheduled to return for his next assigned shift on 08/06/25 at 6:00 pm, but he contacted CNA #1 and informed him he was suspended from work pending the outcome of an abuse investigation. The ADM stated he began his investigation with the help of the SSD. The Administrator stated they interviewed other residents regarding any sexual abuse, and they utilized a questionnaire that included a question asking if the resident had been sexually abused. The Administrator stated all other residents answered no to the question. The Administrator stated R #96 was interviewed about the incident, and the Administrator believed her main concern was to have no further contact with CNA #1. The Administrator stated R #96's allegations regarding CNA #1 could not be confirmed. The Administrator stated he did not substantiate the allegation of abuse. He stated he contacted CNA #1 and said he was clear to return to work that night provided he did not have any further contact with R #96. The Administrator stated CNA #1 was assigned to another hall in another part of the building following the incident. The Administrator stated he was informed of new allegations of abuse on 08/22/25 in which CNA #1 was accused of abusing R # 46 and R #120. The Administrator stated he immediately contacted CNA #1's agency when he learned of these new allegations of abuse on 08/22/25, and he informed them CNA #1 was not to return to the facility. He stated he told the agency he would not be hired for future contract work. T. On 09/02/2025 at 4:11 pm during interview, the SSD stated she was told by R #96 that there were a couple of incidents that made her (R #96) uncomfortable. She stated R #96 reported CNA #1 would hug her when she did not want to be hugged, CNA #1 would say she looked ashy and needed lotion, and CNA #1's finger slipped into her rectum when he changed her brief. The SSD stated she spoke with R #96 as well as presenting a sex abuse questionnaire to multiple residents (no residents were identified specifically by SSD). The SSD stated she provided the Administrator her investigation, and she informed the Administrator that other residents did not have any issues regarding staff care. The SSD stated the Administrator determined the allegations were unsubstantiated. The SSD stated she told the Administrator she believed the abuse occurred and the report should be substantiated. On 08/27/25 at 12:29 pm, the Administrator was notified of a finding of Immediate Jeopardy (IJ). On 08/29/25 at 10:40 am, the facility provided a Plan of Removal (POR) which included the following: Corrective Action (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All residents have the potential to be affected by this alleged deficient practice. The following measures and monitoring will be completed by 08/27/25. Facility sent in late reportable for the second and third identified residents on 08/26/25 and 08/27/25. Change in Condition with provider and responsible parties notified 08/21/25. Whole house abuse questionnaire completed with residents 08/27/25. Skin check for residents involved as appropriate 08/21/25. Psychiatric service referral for residents involved as appropriate 08/21/25. CNA in question was terminated 08/21/25. Systemic Measures Starting 08/27/25 the Center leadership staff will be re-educated on the following areas by Market Resource Nurse. Investigations start with removal of staff member and protection of resident. Abuse questionnaires to be completed by those who have the potential to be affected by the staff member or resident. Individual self-reports to follow for any other residents who are identified during the questionnaires. Change in condition with provider and responsible party notification for those affected or impacted. Skin checks for residents involved as appropriate Social services to complete wellness checks and offer psychosocial support as appropriate. Psychiatric services referral for residents involved as appropriate. The scope and severity were reduced from a K to an E. Implementation of the POR was verified by the following: - Record review of the facility's Abuse and Neglect training, dated 08/27/25, revealed all nursing staff were trained to recognize and report any abuse including involuntary seclusion, unwanted physical contact, misappropriation, verbal abuse, or mental abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 08/28/25 at 10:00 am multiple nursing staff were contacted and interviewed. Each confirmed they had been provided re-education regarding abuse and neglect. Each confirmed they had been provided this training individually by the Nurse Practice Educator on 08/27/25. Each nursing staff interviewed was able to give a description of the training content and what was expected of them to recognize and report abuse. - On 08/29/25 at 10:54 am during interview with the Nurse Practice Educator, she stated she personally met with all nursing staff and provided each with the required re-education and re-training to recognize and report abuse. - On 09/01/25 at 9:30 am during observation of all areas of the facility, staff were observed as they interacted with residents, provided care and assistance to residents and provided meals to residents. All staff were observed to interact in a respectful and dignified manner.

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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. Based on record review and interviews, the facility failed to follow provider orders for 2 (R #3 and R#121) of 2 (R #3 and R#121) residents when staff failed:-Complete, relay and document weekly Prothrombin Time and International Normalized Ratio (PT/INR) (a test administered to monitor and manage blood levels of Warfarin-a blood thinning medication) laboratory results for R #3. -Follow physician order for oxygen use for R#121. These deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are:R#3 A) On 9/3/25, record review of R 33's Physician's Orders revealed an order to check INR every Monday, call result to provider and enter nursing note with result, provider you spoke with, and any new orders received. B) Record review of R #3's daily nursing notes failed to show any documentation on 07/07/25, 07/14/25, 08/04/25, 08/11/25, 08/18/25, and 09/01/25 that INR was completed, recorded, provider notified and new orders. C) On 09/03/25 at 9:31 AM during an interview with the Director of Nursing (DON), she stated the in house INR is done every Monday per order and nursing staff is to document all results in the progress notes including conversations with the assigned provider. DON confirmed the documentation was incomplete and verified that there was no documentation regarding INR results before 07/07/25. R#121 D) Record review of R #121's physician order revealed #121 is on continuous oxygen to keep oxygen saturation level greater than 88%. E) On 09/05/25 at 10:32 AM, during a telephone interview with the Hospice Registered (HR) nurse, assigned to R #121 stated on one of his visits, he witnessed a staff walking the resident in the hallway with no oxygen on. He quickly checked her oxygen saturation level, and it was 82%. He notified all visible staff at the nurse's station to get an oxygen tank and return the resident back to her room where she has her own oxygen concentrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325036	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Palomas Center	8100 Palomas Avenue 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 3 (R #'s 5, 15, and 9) of 3 (R #'s 5, 15, and 9) residents reviewed for ADL care by staff failing to: Providing assistance for baths and showers.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 R #5 was admitted into the facility on [DATE]. B. Record review of R #5's care plan dated 07/18/25 revealed R #5 required ADL assistance for bathing due to R #5 having limited mobility and being legally blind. C. Record review of the facility's shower schedule revealed R #5's bath/showers were scheduled for Tuesdays and Fridays. D. Record review of R #5's documentation survey report (Activities of Daily Living - ADL tracking form), dated 06/01/25 through 06/30/25 revealed R #5 was offered/given 3 showers out of 8 opportunities. E. Record review of R #5's shower sheets dated 06/01/25 through 06/30/25 revealed R #5 was offered/given 3 showers out of 8 opportunities. F. Record review of R #5's documentation survey report dated 07/01/25 through 07/31/25 revealed R #5 was offered/given 1 shower out of 6 opportunities. G. Record review of R #5's shower sheets dated 07/01/25 through 07/31/25 revealed R #5 was offered/given 3 showers out of 6 opportunities. H. Record review of R #5's documentation survey report dated 08/01/25 through 08/31/25 revealed R #5 was offered/given 2 showers out of 9 opportunities. I. Record review of R #5's shower sheets dated 08/01/25 through 08/31/25 revealed R #5 was offered/given 5 showers out of 9 opportunities. J. On 08/26/2025 at 10:23 am during an interview and observation with R #5, he stated that he does not always get showered per his shower schedule. R #5 was observed to be unkempt (messy and without sings of a recent bath/shower) and have dirty nails. K. On 09/02/25 at 5:27 pm during an interview with Nursing Assistant (NA) #1, she stated that R #5 enjoys showers, and he does not refuse them often. L. On 09/03/25 at 12:16 pm during an interview with Certified Nursing Assistant (CNA) #3, she stated that showers/baths are documented in the electronic health record (documentation survey report) and shower sheets. CNA #3 also stated that she did not recall R #5 refusing baths/showers and he liked them. M. On 09/03/25 at 12:43 pm during an interview with Registered Nurse (RN) 31, she stated that she was not aware of R #5 refusing baths/showers. RN #1 also stated that baths/showers should be offered to residents per their shower schedule. N. On 09/04/25 at 4:35 pm during an interview with the Director of Nursing (DON), she stated residents should be offered baths/showers per the shower schedule and at least twice a week. The DON confirmed all baths/showers should be documented when completed or a resident refused, and R #5 was not offered/given enough showers and should have been. R #15: (continued on next page)

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	325036	A. Building B. Wing	09/09/2025

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Las Palomas Center	8100 Palomas Avenue NE Albuquerque, NM 87109

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. Record review of R #15's face sheet revealed R #15 was admitted into the facility on [DATE]. P. Record review of R #15's care plan dated 07/10/25 revealed R #15 required ADL assistance for bathing due to cognitive impairments (problems with mental functions). Q. Record review of the facility's shower schedule revealed R #15's bath/showers were scheduled for Wednesday and Saturday. R. Record review of R #15's documentation survey report dated 06/01/25 through 06/30/25 revealed R #15 was offered/given 1 shower out of 8 opportunities. S. Record review of R #15's shower sheets dated 06/01/25 through 06/30/25 revealed R #15 was offered/given 3 showers out of 8 opportunities. T. Record review of R #15's documentation survey report dated 07/01/25 through 07/31/25 revealed R #15 was offered/given 4 showers out of 9 opportunities. U. Record review of R #15's shower sheets dated 07/01/25 through 07/31/25 revealed R #15 was offered/given 7 showers out of 9 opportunities. V. Record review of R #15's documentation survey report dated 08/01/25 through 08/31/25 revealed R #15 was offered/given 4 showers out of 9 opportunities. W. Record review of R #15's shower sheets dated 08/01/25 through 08/31/25 revealed R #15 was offered/given 5 showers out of 9 opportunities. X. On 08/26/2025 at 2:18 pm during an interview with R #15, she stated that she would like at least two showers a week, but she does not get that often. R #15 also stated that she becomes frustrated when she is not given at least two showers a week. Y. On 09/02/25 at 5:25 pm during an interview with NA #1, she stated that R #15 likes to receive showers and does not refuse them. Z. On 09/02/25 at 5:37 pm during an interview with CNA #2, she stated R #15 likes showers, but she does not always get one because of staffing. AA. On 09/03/25 at 11:54 am during an interview with LPN #1, she confirmed R #15 likes to receive showers and R #15 does not refuse them. BB. On 09/04/25 at 4:36 pm during an interview with the DON, she confirmed R #15 was not offered enough baths/showers and should have been. R # 9 CC. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. DD. Record review of R #9's care plan dated 06/04/25 revealed R #9 requires ADL assistance for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion (ability to get from one place to another in wheelchair or on foot), and toileting related to: Paralysis/Weakness, and limited mobility. EE. Record review of the facility's shower schedule revealed R #9's bath/showers were scheduled for Mondays and Thursdays. FF. Record review of R #9's shower sheets dated 06/01/25 through 06/30/25 revealed R #9 was given 4 showers out of 8 opportunities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GG. Record review of R #9's documentation survey report (DSR), dated 07/01/25 through 07/31/25, revealed R #9 was given a shower 6 out of 10 opportunities. HH. Record review of R #9's documentation survey report dated 08/01/25 through 08/31/25 revealed R #9 was offered/given 5 showers out of 10 opportunities. II. On 08/26/25 at 3:47 pm during an interview with the Resident Representative (RR), she stated there was an issue with showers, and R #9 did not get showers regularly, and was soiled on some visit occasions. R #9 complains to me at every visit that she is not getting bathed enough. JJ. On 09/03/25 at 9:30 am during an interview with the Director of Nursing (DON), she stated the expectation for shower sheet completion is the sheets will be reviewed by staff then given to Medical records for upload the same day. The DON stated there have been issues with the charting program, but there has been an increase in documentation across the board since the implementation of the shower sheet requirement for staff. KK. On 09/03/25 at 5:02 pm during an interview with the DON, she stated staff should document if it was refused for bed baths or showers regardless of the outcome. She stated showers should always be offered two times per week, and she could not explain blank spaces or missing documentation.