STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325042	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Rehabilitation Center	7900 Constitution Avenue NE Albuquerque, NM 87110

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41988 Based on observation, record review, and interview, the facility failed to maintain an environment that was clean, in good condition, and free from clutter for all residents who resided on the 400 Unit and were sampled for a homelike environment. Failure to maintain the building in a clean and comfortable manner is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. The findings are: A. On 08/14/24 at 9:48 am during a 400 unit observation, three mattresses and an oxygen (O2) concentrator (machine used to deliver O2) were observed on the floor, against the hallway railings and by room (RM) #401. B. On 08/14/24 at 11:45 am during an interview with Registered Nurse (RN) #3, she confirmed the above findings and stated those should not have been left in the Unit hallway by RM #401. C. On 08/15/24 at 4:43 pm during a 400 unit observation, a bedside commode (portable toilet) was observed to be outside of RM #408, against the wall and below the hand rail. D. On 08/16/24 at 9:37 am during a 400 unit observation, a bedside commode (portable toilet) was observed to be outside of RM #408, against the wall, and below the hand rail. E. On 08/16/24 at 10:36 am during an interview with Licensed Practical Nurse (LPN) #1, she stated the bedside commode had been in that spot for a while, and it should not be there. F. On 08/16/24 at 3:15 pm during an interview with the Administrator (ADM), she stated the company that collected the mattresses liked them in a visible spot. She stated the mattresses, O2 concentrator, and bedside commode should not have been in the unit hallway for an extended period of time.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024

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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 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** 47091 Based on record review and interview, the facility failed to ensure a resident's belongs were safeguarded from loss for 1 (R #2) of 1 (R #2) residents reviewed for personal property when they failed to offer R #2 a safe place for her belongings until after theft occurred. This deficient practice is likely to result in unaccounted property for the resident and family resulting in frustration. The findings are: A. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE]. B. Record review of R #2's complaint narrative investigation report, dated 07/12/2, revealed R #2 reported on 07/12/24 that a check in the amount of $800.00 was missing out of her dresser. C. Record review of R #2's complaint narrative investigation report, dated 07/12/2, revealed Facility Actions: Business Office Manager (BOM) immediately reviewed resident trust account and found the check was cashed on 07/05/24 via mobile deposit into a bank account. The BOM immediately notified the facility's bank and filed a fraud claim on the check. The BOM filed a police report. D. On 08/16/24 at 9:37 am during an interview with R #2, she stated she spoke with the business office about the incident. She stated, Someone stole a check for $800.00 from my dresser. I am still waiting to be reimbursed. They have not offered me a safe place to keep my belongings. E. On 08/16/24 at 9:54 am during interview with the Business Office Manager, she confirmed R #2 was still waiting to be reimbursed. She stated R #2's check was deposited into a BMO bank account. amd a police report was filed. The BOM stated the claims department sent an email stating the claim was accepted, but it could take 30 to 120 days for them to investigate it. F. On 08/16/24 at 3:07 pm during an interview with the Administrator, she stated R #2 was not offered a safe place to keep her belongings until after the theft had occurred. She further stated it was not their policy to offer a place for residents to keep their belongings, and it was done as an exception due to the incident that occurred.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to meet professional standards of quality for 2 (R #7 and R #9) of 4 (R #5, #7, #8 and #9) residents when staff: 1. Did not provide care or assess R #7 for several hours upon admission. 2. Did not offer R #7 hydration or a snack for several hours upon admission. 3. Nursing staff did not obtain physician orders for R #9's Peripherally Inserted Central Catheter (PICC; a long, thin tube that is inserted through a vein in your arm and passed through to the larger veins near your heart) line care, monitoring, and dressing changes. 4. Nursing staff did not provide PICC line care, monitoring, and dressing changes for R #9 until R #9 was discharged from the facility If the facility is not providing care, hydration, or assessing a resident after an admission, then residents are likely to not receive the therapeutic benefits and care needed. The findings are: R #7 A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] and was discharged to the hospital on 04/24/24 at 5:00 am. B. Record review of R #7's nursing progress notes, dated 04/23/24 through 04/24/24, revealed the following: 1. On 04/23/24 at 6:30 pm: R #7 arrived to the facility via ambulance. 2. On 04/23/24 at 10:49 pm: staff completed R #7's elopement evaluation (an assessment to determine a resident's risk of leaving the facility without staff knowledge.) 3. On 04/23/24 at 10:50 pm: staff completed R #7's clinical admission (an assessment to determine nursing needs) 4. On 04/23/24 at 10:53 pm: staff completed R #7's social determinants of health (an assessment to determine non-medical factors that impact health outcomes.) 5. On 04/23/24 at 10:54 pm: staff completed R #7's bed rail evaluation (an asssessment to determine safety) 6. On 04/23/24 at 11:02 pm: staff completed R #7's pain assessment (an assessment to determine a if a resident has pain.) 7. On 04/23/24 at 11:30 pm: staff completed R #7's R #7 fall risk assessment (an assessment to determine a resident's risk of falling.) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of R #7's documentation survey report (Activities of Daily Living- ADL tracking form), dated 04/23/24 through 04/24/24, revealed R #7 was offered a drink and snack one time at 3:18 am on on 04/24/24. D. On 08/14/24 at 10:34 am during an interview with R #7's sister, she stated when R #7 arrived to the facility his room was not ready for him, and they waited approximately 30 minutes for a Certified Nursing Assistant (CNA) to set up R #7's bed. R #7's sister also stated a nurse did not see or approach R #7 for approximately three hours due to the Registered Nurse (RN) stating she was busy with medications and couldn't do that [assess the resident]. R #7's sister confirmed she and R #7 asked multiple times for water and a snack while they waited, but staff did not provide them. E. On 08/15/24 at 4:53 pm during an interview with RN #1, she stated R #7 arrived to the facility after shift change, and she was the admitting nurse for R #7. RN #1 stated R #7's room was not completely set up when he arrived. She stated she administered medications to other residents, and she assessed R #7 as soon as she could. RN #1 further stated any staff could have offered the resident hydration or snacks. F. On 08/16/24 at 3:31 pm during an interview with the Unit Manager (UM) #1, he stated residents should not wait several hours to be seen and assessed by the nursing staff when they arrive to the facility for the first time. UM #1 stated staff should offer the residents hydration and a snack if they arrived after meal service has ended. G. On 08/16/24 at 5:08 pm during an interview with the Director of Nursing (DON), she stated the expectation was for staff to greet residents when they are admitted into the facility, orient the resident to the facility, give hydration or snacks if needed, and constantly check on the resident until assessments are completed. R #9 H. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE] and was discharged on [DATE]. I. Record review of R #9's hospital discharge orders, dated 06/05/24, revealed an order to continue right arm PICC, for intravenous (IV; in the vein) antibiotic administration. J. Record review of R #9's facility physician orders located in R #9's Electronic Health Record (EHR) revealed the record did not contain an order for PICC line monitoring, dressing changes, or care were present. K. Record review of R #9's nursing progress notes, dated 06/21/24, revealed nursing staff assessed R #9's PICC line for the first time and changed the PICC line dressing for the first time, prior to R #9 discharge. L. On 08/15/24 at 12:37 pm during an interview with R #9's sister, she stated staff were supposed to monitor R #9's PICC line and change the PICC line dressing every seven days, but they did not. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 08/15/24 at 4:56 pm during an interview with Registered Nurse (RN) #1, she stated a resident;s PICC lines should be monitored and assessed daily, and the resident's EHR should contain a physician's order to change the PICC line dressing weekly. N. On 08/16/24 at 12:19 pm during an interview with RN #2, she stated Unit Manager (UM) #1 told her to change R #9's PICC line dressing on 06/21/14 before R #9 was discharged . RN #2 stated the resident's EHR should have contained a physician order to monitor R #9's PICC line and change R #9's PICC line, but there was not orders in the resident's record. RN #2 confirmed she was the only staff who changed R #9's PICC line, and she did it once on 06/21/24. O. On 08/16/24 at 3:40 pm during an interview with the UM #1, he stated R #9's EHR should have contained physician orders for R #9's PICC line monitoring and PICC line dressing changes, but it did not. UM #1 stated staff should have changed R #9's PICC line dressing every seven days, but they did not. P. On 08/16/24 at 5:11 pm during an interview with the Director of Nursing (DON), she stated the admitting nurse should have made sure R #9's PICC line monitoring and dressing change physician orders were in the resident's EHR upon admission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 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) assistance for baths and showers by the facility staff for 5 (R #5, #8, #9, #10, and #11) of 5 (R #5, #8, #9, #10, and #11) residents reviewed for ADL care. 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 06/13/24 revealed the following: - Focus: Resident/Patient requires assistance, was dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to recent illness, fall, hospitalization . - Interventions: Arrange resident environment as much as possible to facilitate ADL performance. C. Record review of the facility's shower schedule revealed staff should offer and give R #5 a bed bath or shower on Tuesdays and Fridays. D. Record review of R #5's documentation survey report (ADL tracking form located in the Electronic Health Record- EHR), dated 07/01/24 through 07/31/24, revealed staff offered and gave R #5 two bed baths or showers out of nine opportunities. E. Record review of R #5's documentation survey report, dated 08/01/24 through 08/16/24, revealed staff offered and gave R #5 four bed baths or showers out of five opportunities. F. On 08/16/24 at 1:36 pm during an interview with R #5, she stated she mostly received one shower a week and preferred at least two. R #5 stated, I feel gross, and I have an itchy scalp when she did not receive at least two showers a week. G. On 08/16/24 at 4:42 pm during and interview with Certified Nursing Assistant (CNA) #1, she stated R #5 should be offered and given at least two bed baths or showers a week, and R #5 did not refuse bed baths or showers. CNA #1 stated staff document all resident baths and showers in the EHR, bed bath or shower refusals should be documented in the EHR also, and all residents should be offered at least two bed baths or showers or whatever was scheduled for that resident. H. On 08/16/24 at 5:14 pm during an interview with the Director of Nursing (DON), she stated staff did not offer or give R #5 bed baths or showers per her preference and schedule, and they should have. R #8: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE] and she was discharged to the emergency room (ER) on 04/22/24. J. Record review of R #8's care plan, dated 04/18/24, revealed the resident required assistance, was dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to recent illness, fall, hospitalization . K. Record review of the facility's shower schedule revealed staff should offer and give R #8 a bed bath or shower on Wednesdays and Saturdays. L. Record review of R #8's documentation survey report, dated 04/17/24 through 04/22/24, revealed staff offered and gave R #8 one bed bath or shower out of two opportunities. M. On 08/14/24 at 1:50 pm during an interview with R #8, she stated she asked for multiple bed baths or showers while she was at the facility, but she only received one. N. On 08/16/24 at 5:14 pm during an interview with the DON, she stated staff did not offer or give R #8 enough bed baths or showers while R #8 was in the facility. R #9: O. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE] and was discharged on [DATE]. P. Record review of R #9's care plan, dated 06/06/24, revealed the resident required assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to recent illness, hospitalization . Q. Record review of the facility's shower schedule revealed staff should offer and give R #9 a bed bath or shower on Mondays and Thursdays. R. Record review of R #9's documentation survey report, dated 06/05/24 through 06/21/24, revealed staff offered and gave R #9 one bed bath or shower out of five opportunities. S. On 08/15/24 at 12:34 pm during an interview with R #9's sister, she stated staff offered and gave R #9 one bed bath or shower while he was in the facility. R #9's sister stated she repeatedly asked staff to give R #9 a bed bath or shower, but they only did once. T. On 08/16/24 at 12:16 pm during an interview with Registered Nurse (RN) #2, she stated she only recalled staff offering and giving R #9 a bed bath or shower one time. U. On 08/16/24 at 5:15 pm during an interview with the DON, she stated staff did not offer or give R #9 enough bed baths or showers while R #9 was in the facility. R #10: V. Record review of R #10's face sheet revealed R #10 was admitted into the facility on [DATE] and was discharged from the facility on 07/25/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	W. Record review of R #10's care plan, dated 07/06/24, revealed the resident was at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to a recent hospitalization related to polytrauma (injuries to multiple body parts and organ systems) which resulted in fatigue, activity intolerance, and impaired mobility. X. Record review of R #10's facility's shower schedule revealed staff should offer and give R #10 a bed bath or shower on Tuesdays and Fridays. Y. Record review of R #10's grievance/concern form, dated 07/13/24, revealed R #10 filed a grievance with the facility because she did not receive a shower as scheduled. Z. Record review of R #10's documentation survey report, dated 07/05/24 through 07/25/24, revealed staff offered and gave R #10 three bed bath or shower out of six opportunities. AA. On 08/15/24 at 2:30 pm during an interview with R #10's Stepfather, he stated R #10 was in the facility because R #10 recently had one of her legs amputated. He stated R #10 wanted more bed baths or showers than what staff offered or provided to her. BB. On 08/16/24 at 10:29 am during an interview with Licensed Practical Nurse (LPN) #1, she stated R #10 and R #10's Stepfather told her on several occasions that R #10 was upset because R #10 did not receive showers as scheduled. CC. On 08/16/24 at 5:16 pm during an interview with the DON, she stated staff did not offer or give R #10 enough bed baths or showers while R #10 was in the facility. R #11: DD. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE] and was discharged on [DATE]. EE. Record review of R #11's care plan, dated 06/22/24, revealed the resident was at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreassed appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others.) FF. Record review of the facility's shower schedule revealed staff should offer and give R #11 a bed bath or shower on Wednesdays and Saturdays. GG. Record review of R #11's documentation survey report, dated 06/22/24 through 06/30/24, revealed staff did not offer or give R #11 a bed bath or shower during that time. HH. Record review of R #11's documentation survey report, dated 07/01/24 through 07/31/24, revealed staff did not offer and give R #11 a bed bath or shower during that time. II. On 08/16/24 at 10:29 am during an interview with LPN #1, she stated staff should have offered or gave R #11 at least two bed baths or showers a week, but they did not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	JJ. On 08/16/24 at 5:16 pm during an interview with the DON, she stated staff did not offer or give R #11 enough bed baths or showers while R #11 was in the facility.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41988 Based on record review, observations, and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all 116 residents who resided in the facility when staff failed to offer baths or showers to residents as scheduled. These deficient practices are likely to negatively impact resident comfort. The findings are: A. Refer to F0677 for findings related to baths/showers. B. On 08/16/24 at 10:32 am during an interview with Licensed Practical Nurse (LPN) #1, she stated there was a shortage of staff at times. She stated she saw most bath or shower problems during the night shift and not the day shift. C. On 08/16/24 at 11:14 am during an interview with an anonymous staff member (ASM), they stated the facility was understaffed and a lot of the staff wasburnt out due to it. The ASM stated residents went without bathsor showers frequently due to the lack of staff, and nurses had to give baths or showers most of the time to make up for the lack of staff available. The ASM confirmed the residents' needs are not met because of the lack of staffing. D. On 08/16/24 at 12:23 pm during an interview with Registered Nurse (RN) #2, she stated staffing has been a problem, and residents missed baths or showers due to it. RN #2 stated the weekends were most affected by the lack of sufficient staffing. E. On 08/16/24 at 5:22 pm during an interview with the Director of Nursing (DON), she stated the facility has been affected by staffing issues, but they do the best they can to meet the needs of the residents.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on observation, record review, and interview, and the facility failed to ensure the medical records for residents were accurate and complete for 2 (R #1 and R #7) of 2 (R #1 and R #7) residents randomly selected and reviewed when staff failed to ensure residents' medication was available and documented they administered prescribed medications when the medications were not available or when resident refused. This deficient practice is likely to result in staff confusion as to when or if residents have consistently received prescribed medications and if residents are receiving their intended medication effectiveness. The findings are: Findings for R #1: A. Record review of R #1 Medications Administration Record (MAR), dated August 2024, revealed staff documented they administered the following medications: - Breyna inhaler [budesonide (a bronchodilator)/formoterol (a steroid); generic; an inhaled medication to expand lungs and airway.] Give two puffs inhaled orally, two times a day. - On 08/01/24 thru 08/06/24, staff documented they administered the medication. - On 08/10/24 thru 08/13/24, staff documented they administered the medication. B. On 08/16/24 at 10:44 am during an interview with R #1 he stated he did not receive his Symbicort inhaler [budesonide/formoterol; name brand; an inhaled medication to expand lungs and airway] for a week and a half. He further stated staff offered him a generic, but he informed nursing staff he could not take it due to it increased his intraocular pressure (pressure inside the eyes). C. On 08/16/24 at 11:35 am during an interview, R #1 Registered Nurse (RN) #4 entered R #1's room to administer medications. R #1 refused the Breyna inhaler and stated it increased intraocular pressure. RN #4 stated R #1 took this inhaler regularly, and he has taken it before. D. On 08/16/24 at 11:35 am during random observation of medication pass for R #1, staff offered the Breyna inhaler to R #1. The inhaler box was opened and dated 07/29/24. The Breyna inhaler was not used as indicated by the metered dose (counter that counts down when inhaler was used) which indicated 122 inhalations left. (120 -122 doses per canister) E. On 08/16/24 at 11:38 am during interview with RN #4, she confirmed the Breyna inhaler meter indicated 122 inhalations left which indicated it had not been administered. She stated she did not know why the inhaler was in the box unused, but the box indicated the inhaler was opened on 07/29/24. RN #4 stated she did not know why the resident's MAR stated the inhaler was administered but the inhaler indicated it had not been used. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Uptown Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 Constitution Avenue NE Albuquerque, NM 87110	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 08/16/24 at 3:17 pm during interview with Unit Manager (UM), he stated it was his expectation that the floor nurse inform him when a resident refused medication or reported any side effects. He further stated staff should document in the resident's MAR R for refused, and they should not document the medication as administered. G. On 08/16/24 at 4:52 pm during interview with the Director of Nursing (DON), she stated R #1's insurance would not cover the Symbicort inhaler. She stated she was aware R #1 reported the Breyna increased his intraocular pressure. She further stated her expectation would be for the nurse to document R on the MAR to indicate the medication was refused. 41988 R #7: H. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] and was discharged to the hospital on 04/24/24 at 5:00 am. I. Record review of R #7's nursing progress notes, dated 04/23/24 at 6:30 pm, revealed R #7 arrived to the facility via ambulance. J. Record review of R #7's MAR and Treatment Administration Record (TAR), dated April 2024, revealed staff documented they administered the following medications to R #7: - Lactulose oral solution, 20 grams (g) / (per) 30 milliliters (ml). Give 30 ml by mouth three times a day for cirrhosis (degenerative disease of the liver resulting in scarring and liver failure). Administered on 04/23/24 at 7:00 pm. - Ceftriaxone sodium injection solution reconstituted, 2 g. Use 2 g intravenously (into or by means of a vein or veins) two times a day for endocarditis (inflammation of the inner lining of the heart chambers and valves) until 05/28/2024. Administered on 04/23/24 at 7:00 pm. K. Record review of R #7's nursing progress notes revealed the following: - Dated 04/23/24 at 9:39 pm, R #7's lactulose was not available and waiting for delivery. - Dated 04/24/24 at 3:04 am, R #7's ceftriaxone sodium was not available and waiting for the order. L. On 08/14/24 at 10:31 am during an interview with R #7's sister, she stated she arrived to the facility at the same time R #7 arrived, and the facility did not provide R #7 any medications while she was there. R #7's sister stated she left the facility sometime after 11:00 pm on 04/23/24, and R #7 still did not receive his medications. M. On 08/15/24 at 4:50 pm during an interview with Registered Nurse (RN) #1, she stated she was in the facility when R #7 arrived on 04/23/24, and she was the one who admitted R #7 upon his arrival. RN #1 stated she did not recall giving R #7 all of his medications when he arrived, because not all of R #7's medications were available. RN #1 did not recall what medications were not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Uptown Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 Constitution Avenue NE Albuquerque, NM 87110	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. On 08/16/24 at 5:08 pm during an interview with the Director of Nursing (DON), she stated nursing staff should not document on a resident's MAR that medications were administered if the medications were not available. She stated the nursing staff should notify a provider if that happened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325042	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Rehabilitation Center	7900 Constitution Avenue NE Albuquerque, NM 87110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47091 Based on observation, interview, and record review, the facility failed to provide proper infection control practices for 2 (R #5 and R #6) of 2 (R #5 and R #6) residents reviewed for wound care when staff failed to: 1. Change gloves after cleaning a wound and before placing a clean bandage on wound. 2. Ensure clean bandages and gloves did not touch a non-clean surface (bed, bedside tray table). 3. Dispose of soiled bandages in a receptacle for items that contained biohazards waste. If the facility is not using proper infection control practices the residents are likely to acquire infections. The findings are: Findings for R #5 A. On 08/14/24 at 1:32 pm, observation of wound care for R #5 revealed the following: 1. LPN #2 placed the clean bandages on R #5's bedside table (a non-clean surface.) 2. LPN #2 did not change her gloves and perform hand washing after cleaning R #5's wound and before she applied the clean bandages from R #5's bedside table to the wound. Findings for R #6 B. On 08/14/24 at 2:30 pm observation of wound care for R # 6 revealed the following: 1. The Wound Care (WC) nurse placed clean gloves on R #6's bed (a non-clean surface.) 2. The WC nurse placed clean bandages on R #6's bedside table which contained food items (a non-clean surface.) 3. The WC nurse discarded the soiled bandages in a non-biohazard receptacle (R #6's bedside trash can). C. On 08/14/24 at 5:01 pm during interview with Director of Nursing (DON), she stated it was her expectation all staff used proper infection control practices such as changing gloves, washing hands, using clean surfaces, and placing their initials, the date, and time on bandages when applying them. She further stated staff should place all soiled bandages in biohazard receptacles.