

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 11/14/2024
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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review, observation, and interview, the facility failed to provide a podiatry consult and care for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for foot care. This deficient practice likely caused R #1 not to receive foot care as ordered by a physician which could result in more serious foot problems. The findings are:</p> <p>A. Record review of R #1's face sheet revealed an initial admitted [DATE]. The resident went to the hospital for a fall on 05/30/24 and was readmitted to the facility on [DATE] with the following list of diagnoses (not all-inclusive):</p> <ul style="list-style-type: none"> - Right femur fracture (break in the thigh bone). - Dementia with agitation (loss of cognitive function with issues such as sleeping or having hallucinations). - Mood disturbance and anxiety (emotional disturbance that impacts emotional health). - Neuropathies (affects the nerves in your body and can be painful). - Dysphagia (difficulty swallowing). <p>B. Record review of R #1's nursing progress notes, dated 05/05/24, revealed R #1 requested to see a podiatrist but refused to allow the nurse to see her feet.</p> <p>C. Record review of R #1's physician order, dated 05/14/24, revealed a podiatry consult was ordered.</p> <p>D. Record review of R #1's wound care evaluation, dated 05/14/24, revealed R #1's first and second toe had an extensive toenail growth, and the 2nd toe appeared to be swollen. R #1's remaining toenails were approximately 1/2 inch long and very yellow in color.</p> <p>E. Record review of R #1's wound care evaluation progress notes revealed the following:</p> <p>(continued on next page)</p>

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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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Dated 05/14/24, R #1 did not have any pain or discomfort at the time. Resident stated she was trying to clip her nails. Surrounding tissue red and fragile. Site cleaned and wound care provided. Podiatry consult in place. Team health notified. Resident started on antibiotic. Educated resident on the importance of not clipping her toe nails. Educated resident on the importance of telling staff of her needs. Will continue to monitor sites.</p> <p>- Completed 11/12/24, R #1's first and second toe appeared to have a growth that was present on the 05/14/24 and still present on the first and second toe. The second toe was enlarged, appeared to be swollen, and appeared to sit on top of the first toe. The toenails were very long and did not appear to be cut recently.</p> <p>F. On 11/13/24 at 10:45 am, during an observation, R #1's second toe rested on top of the first toe. The second toe appeared very large and swollen. The toenails on her other toes were very long and yellow in appearance.</p> <p>G. On 11/13/24 at 10:45 am, during an interview, R #1 stated she had some mild pain with her foot. She stated she did not recall when she saw a foot doctor last.</p> <p>H. On 11/13/24 at 11:10 am, during an interview with Nurse #1, she stated she had not seen R #1's toes before today (11/13/24). She stated R #1 always had on socks, and the Certified Nursing Assistant (CNA) gave R #1 showers at night. She stated podiatry comes to the facility, but she was not sure if they saw R #1. Nurse #1 stated she typically worked the hall that R #1 lived on, and she typically worked three days per week on this hall. Nurse #1 stated she worked for the facility for over a year. Nurse #1 stated she did not cut R #1's toenails and was not allowed to cut R #1's toenails. Nurse #1 stated did not see any notes from podiatry in R #1's medical record.</p> <p>I. On 11/13/24 at 11:33 am during an interview with Unit Manager (UM), she stated she was just made aware of the condition of R #1's toenails. She stated R #1 always wore socks and refused skin checks most of the time. The UM stated R #1 kept her socks on when she did allow staff to do a skin check. She stated the podiatrist was in the facility last week, but R #1 refused to be seen by the podiatrist. The UM stated R #1 did not complain about foot pain to her knowledge. She stated R #1 was very independent.</p> <p>J. On 11/13/24 at 2:00 pm, during an interview with CNA #2, she stated she had showered R #1 several times. CNA #2 stated the last time she showered R #1 was a month or a month-and-a-half ago. CNA #2 stated R #1 liked to wash herself. She stated she was aware of R #1's toenails and reported them to the nurse. CNA #2 stated she also reported to the nurse that R #1's toes crossed over one another. She stated she did not know if a podiatrist saw R #1. She stated the podiatrist did not come to the facility for awhile.</p> <p>K. On 11/14/24 at 9:45 am during an interview with UM, she stated that when the podiatrist came to the facility, they would see residents with diabetes first and then residents that needed to be seen. She stated a technician would come to the facility to perform nail and toe care. She stated the technician trimmed and filed the residents' toenails, as needed. The UM stated it was not a podiatrist that performed the residents' toe and nail care. She stated R #1 needed on-going care with a podiatry specialist.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>L. On 11/14/24 at 10:29 am, during an interview with the Administrator, she stated she was under the assumption that the podiatrist came and saw the residents. She stated the technicians were the ones who performed the toe and nail care and saw the residents. The Administrator stated R #1 did not have any documentation in her medical record to show a podiatrist saw R #1 after the physician order dated 05/14/24. The Administrator further stated the podiatrist had not been to the facility in July, August, and September of 2024.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>35632</p> <p>Based on record review and interview, the facility failed to ensure medical records were updated with necessary documents and accurate for 2 (R #1 and #2) of 2 (R #1 and #2) residents reviewed for foot care. This deficient practice could likely result in staff not knowing residents' daily care events, changes, and their needs. The findings are.</p> <p>R #1</p> <p>A. Record review R #1's nursing progress notes, dated 05/05/24, indicated R #1 requested to see a podiatrist but refused to allow the nurse to see her feet.</p> <p>B. Record review of R #1's physician order, dated 05/14/24, indicated a podiatry consult was ordered.</p> <p>C. Record review of R #1's electronic medical record (EMR) revealed the records did not contain documentation a podiatrist saw R #1 after 5/14/24 or that R #1 refused podiatry care.</p> <p>D. On 11/14/24 at 10:29 am, during an interview, the Administrator confirmed R #1's chart did not contain updated podiatry documentation. The Administrator stated R #2 frequently refused care, to include monthly podiatrist visits, and was now scheduled to see the podiatrist yearly. The Administrator confirmed staff did not document R #1's refusal of the podiatry visit in R #1's EMR, and the company who provided the podiatry visits also did not keep a record of refusals.</p> <p>49196</p> <p>R #2</p> <p>E. Record review of R #2's most recent podiatry note, dated 12/22/23, revealed the podiatrist saw R #2, and podiatrist technician provided specialized nail care for R #2. The note recommended follow-up visit every two months.</p> <p>F. Record review of R #2's Electronic Medical Record (EMR) revealed the record did not contain any podiatry notes or documented refusals dated after 12/22/23.</p> <p>G. On 11/13/24 at 2:39 PM during an interview, R #2 stated he did not have an appointment with the podiatrist for at least nine months, and he now managed his own nail care.</p> <p>H. On 11/14/24 at 11:30 AM during an interview, the Administrator explained R #2 frequently refused care, to include the monthly podiatrist visits, and R #2 was now scheduled to see the podiatrist yearly. The Administrator stated R #2 preferred to do his own maintenance nail care. The Administrator stated staff did not document R #2's refusal of the podiatry visit in R #2's EMR, and the company who provided the podiatry visits also did not keep a record of refusals. The Administrator stated staff should have documented the refusals in the residents' medical records.</p>		