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	02/27/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to ensure staff treated residents with dignity and respect for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed when staff failed to consider a resident's feelings due to her pain levels. This deficient practice could likely cause the resident to feel like she was not being heard and did not matter. The findings are: Cross reference with F697. A. Record review of R #1's face sheet revealed she was admitted on [DATE] and discharged on [DATE], with the following diagnoses: - Quadriplegia (paralysis of all four limbs), - Traumatic brain injury (TBI is the result from a violent blow or jolt to the head or body), - Neurogenic bladder (the lack of bladder control due to brain, spinal cord, or nerve problems), - Cognitive communication deficit (consequence of brain injuries that affects a person's ability to communicate effectively), - Cervical subluxation (partial misalignment or displacement of the vertebrae in the neck), - Traumatic nondisplaced spondylolisthesis of cervical vertebra (a condition in which one vertebra in the spine slips forward on another due to an injury), - Fusion of spine (surgery to connect two or more bones in any part of the spine), - Deep dehiscence of wound (when a surgical incision reopens), - Infection of the intervertebral disc (a serious spinal infection that can cause severe pain.) - This is not all inclusive list. B. Record review of R #1's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) revealed a score of 15, cognitively intact. (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

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Uptown Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7900 Constitution Avenue NE Albuquerque, NM 87110	

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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	C. On 02/26/25 at 10:40 am, during an interview with a visitor at the facility (visitor), she stated she visited her grandmother at the facility on 01/08/25. She stated she heard R #1 yell out for help and this was for about half an hour. She said the incident occurred around mid-morning. The visitor stated she heard a staff member yell at the resident (R #1) and said, We hear you. Management is busy. The physician is aware you want to see him. She stated the staff member said other things, but she could not remember exactly what they were. She said the staff member went on for about 30 seconds to a minute. The visitor stated the staff seemed to ignore R #1 as she continued to call out for pain medications for at least 30 minutes. The visitor stated she walked out into the hall and confronted the staff member. She stated she asked the staff member if she was the one yelling at the resident and what her name was. She stated the staff member rolled her eyes and gave her name. D. On 02/25/25 at 11:20 am, during and interview with R #1, she said a staff member yelled at her about seeing the physician while she was at the facility. She stated she could not remember the date the incident happened. She stated staff would not help her, and she was in pain. She stated she yelled at the staff, because she was angry and hurting. E. On 02/26/25 at 11:32 am, during an interview with Certified Nurse Assistant (CNA) #1, she stated she worked with R #1 about one week, and she worked with R #1 on 01/08/25. She stated sometimes R #1 was pleasant to work with and other days R #1 was upset and difficult. She stated R #1 would call out constantly when she needed something, usually her pain medication. CNA #1 said she went into the room to get R #1's vitals, and R #1 screamed at her. CNA #1 said she told R #1 staff were aware she wanted to see the doctor, and they could not give her any more pain medication. CNA #1 told R #1, You are on the list to be seen, and we have addressed your issues. There is nothing that we [staff] can give you [meaning more medications.] CNA #1 said R #1 told her to get the F out of her room. CNA #1 stated she was confronted by another resident's family member when she walked out of R #1's room. She stated the family member told her that she was a bit aggressive with R #1. CNA #1 stated she had to raise her voice a little when she spoke to R #1, because R #1 yelled constantly when she tried to speak with her.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to report to the State Survey Agency (SSA) an allegation of staff to resident abuse for 1 (R #1) of 1 (R #1) resident reviewed for abuse. If the facility fails to report allegations of abuse to the SSA, then corrective measures may not be acted on and the SSA will not be unable to ensure residents are free from abuse. The findings are: A. Record review of R #1's face sheet revealed she was admitted on [DATE] and discharged on [DATE], with the following diagnoses: - Quadriplegia (paralysis of all four limbs), - Traumatic brain injury (TBI is the result from a violent blow or jolt to the head or body), - Neurogenic bladder (the lack of bladder control due to brain, spinal cord, or nerve problems), - Cognitive communication deficit (consequence of brain injuries that affects a person's ability to communicate effectively), - Cervical subluxation (partial misalignment or displacement of the vertebrae in the neck), - Traumatic nondisplaced spondylolisthesis of cervical vertebra (a condition in which one vertebra in the spine slips forward on another due to an injury), - Fusion of spine (surgery to connect two or more bones in any part of the spine), - Deep dehiscence of wound (when a surgical incision reopens), - Infection of the intervertebral disc (a serious spinal infection that can cause severe pain.) - This is not all inclusive list. B. On 02/26/25 at 10:25 am during an interview with Social Services Director (SSD), she stated two ladies who were visiting their family on 01/08/25 came to her office and reported Certified Nursing Assistant (CNA) #1 yelled at one of the residents. The SSD stated an investigation was started, and CNA #1 was suspended while the investigation took place. The SSD said she did her investigation on the same day the allegation was reported to her. The SSD said she did not report the incident to the SSA, and she was not aware if anyone reported the incident. C. On 02/26/25 at 11:15 am, during an interview with the Administrator who is also the Abuse Coordinator, stated she was not aware of the incident that occurred with R #1 on 01/08/25, because she was out of the facility when it occurred. She stated there was an investigation into the incident, but staff did not report it to the SSA.

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice by not following physician orders for 1 (R #2) of 3 (R #2, 3 and 4) residents reviewed for diabetic medications. Failure to follow physician orders is likely to cause residents to not receive the care and treatment they require. The findings are: A. Record review of R #2's face sheet revealed he was admitted on [DATE] with the following diagnoses: - Type II diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar), - Diabetic neuropathy (a type of nerve damage that occurs as a complication with diabetes), - Diabetic ophthalmic complication (damage to eyes caused by diabetes), - Blindness in left eye. - This is not all inclusive list. B. Record review of R #2's physician orders revealed the following orders: - Glipizide (oral diabetes medicine that helps control blood sugar levels) oral tablet. Give 10 milligram (mg) by mouth one time a day for DM2. Start date on 12/20/24. - Metformin HCl oral tablet (used to treat high blood sugars) 1000 mg. Give one tablet by mouth two times a day for DM2. Start date 08/09/24. - Draw A1C (a test to check how high your blood sugars have been over several months) every three months starting on the 20th for one day. Start date 09/20/24. - Insta-Glucose Gel 77.4 % (used to treat very low blood sugar by quickly increasing the blood glucose). Give one dose by mouth as needed for a blood glucose less than 70, if the resident awake, conscious, and able to swallow. Hold all diabetic medications until provider authorizes to start again. Remain with resident. Keep resident in bed/chair for safety. Repeat blood glucose in 15 minutes. Start date 12/19/24. C. Record review of R #2's care plan, dated 11/15/22, revealed the following: - Problem: Diabetes, - Focus: R #2 should be free of all signs and symptoms of hypoglycemia (low blood sugar, normal blood sugar measurement is 70 to 99 mg/dL). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Intervention: Administer hypoglycemic (low blood sugar) medications as ordered. D. Record review of R #2's blood glucose readings, dated 02/01/25 through 02/28/25 revealed staff documented the following: - On 02/11/25 at 5:02 pm, R #2's blood glucose measured 66.0 mg/dL. - On 02/04/25 at 10:22 pm, R #2's blood glucose measured 66.0 mg/dL. - On 02/01/25 at 10:50 pm, R #2's blood glucose measured 68.0 mg/dL. E. Record review of R #2's medication administration record (MAR) for 02/01/25 through 02/28/25, revealed staff did not administer the Insta-Glucose gel as ordered by the physician when R #2's blood glucose measured below 70. F. On 02/26/25 at 9:38 am, during an interview with Unit Manager #1 and the Director of Nursing (DON), Unit Manager #1 stated R #2 had an order for Insta-Glucose gel if his blood sugar measured below 70 mg/dL. She stated staff should follow the order. She stated she expected staff to administer the Insta-Glucose gel if R #2's blood sugar dropped below 70. She stated that the resident always had juice at his bedside and a snack for when he felt his blood sugar was low. G. On 02/26/25 at 3:33 pm, during an interview with Nurse #3, she stated if a resident's blood sugar was below 70, then she would assess the resident and give them juice or a peanut butter and jelly sandwich. Nurse #3 stated you would always follow the resident's physician's order. H. On 02/27/25 at 2:31 pm, during an interview with Nurse #4, she stated if a diabetic resident had a blood sugar below 70, then you should follow the physician's order. She stated staff should check to see if the resident was alert and conscious and and then give them Insta-Glucose gel. Nurse #4 stated staff should not give juice first, and nurses should always follow the physician order.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to manage a resident's pain for 1 (R #1) of 1 (R #1) resident reviewed for pain management. This deficient practice could likely cause a resident to experience a decline physical and emotional health if the resident's pain was not managed and effectively controlled. The findings are: A. Record review of R #1's face sheet revealed she was admitted on [DATE] and discharged on [DATE], with the following diagnoses: - Quadriplegia (paralysis of all four limbs), - Traumatic brain injury (TBI is the result from a violent blow or jolt to the head or body), - Neurogenic bladder (the lack of bladder control due to brain, spinal cord, or nerve problems), - Cognitive communication deficit (consequence of brain injuries that affects a person's ability to communicate effectively), - Cervical subluxation (partial misalignment or displacement of the vertebrae in the neck), - Traumatic nondisplaced spondylolisthesis of cervical vertebra (a condition in which one vertebra in the spine slips forward on another due to an injury), - Fusion of spine (surgery to connect two or more bones in any part of the spine), - Deep dehiscence of wound (when a surgical incision reopens), - Infection of the intervertebral disc (a serious spinal infection that can cause severe pain.) - This is not all inclusive list. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 01/01/25, revealed the following: - Constant pain, - Pain affects the resident's sleep and activities. - Resident rated the pain as a 7 out of 10 (Based on a 0 to 10 pain scale, with 0 being the lowest amount of pain and 10 being the highest amount of pain.) C. Record review of R #1's care plan, dated 12/26/24, revealed R #1 exhibited alterations in comfort related to chronic pain. Interventions included request pain medication before the pain became severe, medicate as ordered by the physician for pain, and monitor medication administration for effectiveness. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review of R #1's current physician orders revealed the following orders: - Oxycodone HCI oral tablet 5 milligram (mg). Give two tablets by mouth every six hours for pain. Start date 01/06/25 and discontinued on 01/08/25. - Oxycodone HCI oral tablet 5 mg. Give one tablet by mouth one time only for pain. Start date 01/08/25. - Oxycodone HCI oral tablet 5 mg. Give two tablets every six hours for pain. Start date 01/08/25 and discontinued on 01/09/25. - Tylenol 325 mg. Give two tablet by mouth every six hours as needed for mild pain. Do not exceed 3 grams per day. Start date 12/26/24. - Gabapentin 100 mg capsule. Give one capsule by mouth three times a day for pain. Start date 12/26/24. E. Record review of R #1's pain evaluations revealed the following: - On 01/07/25 at 1:03 am, staff documented R #1's pain as 0. - On 01/07/25 at 2:09 am, staff documented R #1's pain as 7. - On 01/07/25 at 11:43 am, staff documented R #1's pain as 5. - On 01/07/25 at 2:11 pm, staff documented R #1's pain as 0. - On 01/07/25 at 5:41 pm, staff documented R #1's pain as 0. - On 01/08/25 at 4:08 am, staff documented R #1's pain as 3. - On 01/08/25 at 11:38 am, staff documented R #1's pain as 7. - On 01/08/25 at 12:19 pm, 2:25 pm, and 7:41 pm, staff documented R #1's pain as 0. - On 01/08/25 at 8:28 pm, staff documented R #1's pain as 7. - On 01/08/25 at 11:31 pm, staff documented R #1's pain as 6. - On 01/09/25 at 3:34 pm, staff documented R #1's pain as 9. F. Record review of #1's Medication Administration Record (MAR), dated 01/01/25 through 01/09/25, revealed the following: - Oxycodone HCI oral tablet 5 mg. Give two tablets by mouth every six hours for pain. Start date 01/06/25 and discontinued on 01/08/25. Staff administered the medication as follows: - One dose on 01/06/25, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Three out of four opportunities on 01/07/25, - Two out of four opportunities on 01/08/25. - Staff documented on the MAR to see the resident's nursing notes regarding the missed administrations. - Oxycodone HCI oral tablet 5 mg. Give one tablet by mouth one time only for pain. Start date 01/08/25. - Staff administered one dose on 01/08/25 at 1:47 pm. - Oxycodone HCI oral tablet 5 mg. Give two tablets every six hours for pain. Start date 01/08/25 and discontinued on 01/09/25. Staff administered the medication as follows: - Two out of four opportunities on 01/08/25 at 4:00 pm and 10:00 pm. - Two out of four opportunities on 01/09/25. - R #1 discharged from the facility the afternoon of 01/09/25. - Tylenol 325 mg. Give two tablet by mouth every six hours as needed for mild pain. Staff administered the medication as follows: - One dose on 01/07/25. - One dose on 01/08/25. - Gabapentin 100 mg capsule. Give one capsule three times per day for pain. Staff administered the medication as follows: - Three out of three opportunities on 01/07/25 - Three out of three opportunities on 01/08/25 - Two out of three opportunities on 01/09/25. - R #1 discharged from the facility the afternoon of 01/09/25. G. Record review of R #1's nursing progress notes revealed the following: - Dated 01/07/25 at 5:41 pm, the resident's order for Oxycodone HCI oral tablet, 5 mg, two tablets by mouth every six hours for pain required a new script sent to the pharmacy, because the medication was not available in the the narcotic box. - Dated 01/08/25 at 11:04 am, the resident's order for Oxycodone HCI oral tablet, 5 mg, two tablets by mouth every six for pain was not available, and the facility was awaiting an order for it. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 01/08/25 at 12:13 am, the resident's order for Oxycodone HCI oral tablet, 5 mg, two tablets by mouth every six hours for pain required a new script sent to the pharmacy, because the medication was not available in the the narcotic box. Staff contacted the pharmacy, and the pharmacy stated the supply would be sent after the script replacement. H. Record review of R #1's progress notes with psychiatric history and physical, dated 01/08/25, revealed R #1 reported feeling frustrated and emotionally distressed due to unmanaged pain and inability to access prescribed oxycodone. Resident stated her chronic pain was everywhere and rated it as severe. The resident reported the pain had a long-standing impact on her quality of life and daily functioning. I. On 03/07/25 at 11:16 am, during an interview, Unit Manager (UM) #1 reviewed R #1's MAR and stated R #1 did not get her oxycodone medication a few times on 01/07/25 and 01/08/25. She stated staff administered one dose to R #1 on 01/08/25 at 1:47 pm and that dose was likely from the Pyxis (an automated medication dispensing machine.) She stated the documentation for the times staff did not administer oxycodone to R #1 indicated to see nursing notes, but the nurses notes were not completely clear as to what was going on. UM #1 stated it appeared the pharmacy was waiting for a script from the physician. UM #1 was unable to provide an explanation as to why the nursing staff did not pull oxycodone from the Pyxis the other times it was not available in the medication cart. She stated if a medication was not available in the medication cart for any reason, then staff should pull it from the Pyxis. J. On 03/14/25 at 9:15 am, during an interview with Director of Nursing (DON), she stated the nurse called the on-call provider regarding a refill on the oxycodone, but the on-call provider did not give staff an authorization code to get medication from the Pyxis. She stated the provider saw R #1 on 01/08/25, and the provider gave the nurse an authorization code to get the oxycodone medication out of the Pyxis. She stated staff administered R #1's other prescribed medications to the resident, so she did not go completely without pain medication.