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	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Rehabilitation Center	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 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** Based on record review and interviews, the facility failed to provide quality care that meets professional standards for 2 (R #2 and #4) of 2 (R #2 and #4) residents, when staff failed to: Obtain and review physicianˆordered laboratory testing (controlled testing performed on biological, environmental, or other healthˆrelated samples to support diagnosis, monitoring, prevention, and research of diseases and health conditions) within a timeframe that meets professional standards for R #2 and R #4.This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are:A. Record review of the facility's laboratory (controlled testing is performed on biological, environmental, or other health-related samples to support diagnosis, monitoring, prevention, and research of diseases and health conditions) policy, revised on [DATE], revealed the following: Diagnostic tests (medical procedures that provide objective insights into your body's condition, helping diagnose, monitor, and prevent diseases), including laboratory tests, will be performed as ordered, staff are responsible for notifying the diagnostic service to arrange for testing, and staff are responsible for obtaining the diagnostic test report. All diagnostic test results are reported to the patient's medical provider, and staff are responsible for notifying the physician/advanced practice provider (APP) of diagnostic test results.Critical laboratory values (laboratory test results that fall outside normal reference ranges to such an extent that they indicate an immediate, life-threatening condition requiring prompt clinical intervention) are to be reported immediately, and staff are to document the date and time of physician/APP notification and the provider's response in the medical record. R #2: B. Record reveal of R#2's face sheet revealed an admission date of [DATE] and the following diagnoses: Sepsis (a serious condition in which the body responds improperly to an infection).Morbid (severe) obesity (severely overweight) with alveolar hypoventilation (a condition where the body does not exchange enough carbon dioxide and oxygen in the lungs' air sacs (alveoli), leading to insufficient respiratory function to maintain normal blood carbon dioxide levels). Chronic pain.Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).Chronic embolism (blood clot) and thrombosis (the formation of a blood clot (thrombus) that blocks a blood vessel, either a vein or an artery) of the left femoral vein (vein located in the femur). C. Record review of R #2's care plan, revised on [DATE], revealed R #2 is at risk of sepsis. D. Record review of R #2's physician orders, dated [DATE], revealed orders for staff to obtain laboratory results for a comprehensive metabolic panel (CMP; a blood test that measures 14 substances to assess liver and kidney function, blood sugar, electrolytes, and overall metabolic health), a complete blood count (CBC; a blood test that measures red blood cells, white blood cells, hemoglobin, hematocrit, and platelets to assess overall health and detect medical conditions), c-reactive protein (CRP; blood test measures inflammation in the body and helps assess infection, autoimmune conditions, and cardiovascular risk), a hemoglobin A1C (HgbA1c; blood test to screen, diagnose, or monitor diabetes), and an erythrocyte sedimentation rate (ESR; blood test measures how quickly red blood cells settle in a test tube, indicating the presence of inflammation in the body). E. Record review of R #2's laboratory results, dated [DATE], revealed the following:R #2's laboratory (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specimens were not collected until [DATE], three days after the order was placed, and the results were reported to the facility on [DATE] and [DATE]. Nurse Practitioner (NP) #2 reviewed the laboratory results on [DATE], and R #2's results were abnormal. F. Record review of R #2's nursing progress notes, dated [DATE], revealed the following: NP #1 reviewed R #2's laboratory results, including the CMP, CRP, CBC, A1C, and ESR. NP #1 documented the abnormal laboratory results along with the physician's response to monitor R #2.R #2 was found unresponsive during a routine morning blood glucose (sugar) check. Cardiopulmonary resuscitation (CPR; an emergency procedure combining chest compressions with artificial ventilation) was initiated, and Emergency Medical Services (EMS) was called. Facility nursing staff continued CPR until EMS arrived, and R #2 was pronounced deceased at 7:10 AM. G. On [DATE] at 9:54 AM, during an interview, Registered Nurse (RN) #2 stated she was not aware laboratory tests had been ordered for R #2 or of any concerns for possible sepsis. RN #2 stated she had not received report regarding pending laboratory tests or instructions to monitor the resident for signs or symptoms of sepsis. RN #2 stated if she had been informed of concerns for possible sepsis or pending laboratory testing, she would have followed up and monitored the resident accordingly. H. On [DATE] at 1:15 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated she worked on [DATE] and was unaware laboratory tests had been ordered for R #2 or of any pending laboratory orders. LPN #1 stated she had cared for R #2 during her recent shifts and had not received report regarding pending laboratory tests or instructions to monitor for possible sepsis. LPN #1 stated on [DATE] she found R #2 unresponsive, initiated CPR, and assisted with the emergency response until EMS arrived. I. On [DATE] at 10:27 AM, during an interview, Certified Nursing Assistant (CNA) #1 stated she was not informed laboratory tests had been ordered for R #2 and she was not instructed to monitor the resident for changes in condition related to the pending laboratory tests. R #4: J. Record review of R #4's face sheet revealed an admission date of [DATE] and the following diagnoses: Acute Kidney Failure. Chronic Kidney Disease. Acute Respiratory Failure with Hypoxia (a condition in which the body's tissues are deprived of adequate oxygen, potentially affecting the whole body or specific regions).Chronic Obstructive Pulmonary Disease (COPD; lung disease).Type 2 Diabetes Mellitus (DM2; a disease in which the body cannot make or properly use insulin).Hypertension (high blood pressure). Atrial Fibrillation (A-Fib; irregular heart rhythm). Peripheral Vascular Disease (PVD; poor circulation).Unstageable (a wound that has full thickness tissue loss but is covered with slough (dead tissue) or eschar (dark scab or falling away of dead skin) so that the true depth of the wound cannot be determined) Pressure Ulcer. K. Record review of R #4's physician orders, dated [DATE], revealed an order to obtain laboratory results for potassium, magnesium, a CBC, CMP, and CRP. L. Record review of R #4's laboratory results, dated [DATE], revealed R #4's laboratory specimens were collected on [DATE], and the results were reported to the facility on [DATE], indicating abnormal laboratory findings. M. Record review of R #4's nursing progress notes, dated [DATE], revealed R #4 was transferred to the hospital due to peripheral edema (swelling of the legs, ankles, and feet caused by excess fluid buildup), altered mental status, and hypotension (low blood pressure) in the presence of acute kidney injury. N. On [DATE] at 1:52 PM, during an interview, RN #1 stated if a resident is suspected of having sepsis, an altered mental status, or meets sepsis criteria, the nurse should immediately notify the provider. RN #1 stated the provider should evaluate the resident and order laboratory tests as indicated. RN #1 stated once laboratory orders are entered, the nurse is responsible for confirming the orders, ensuring the orders are transmitted to the laboratory, and arranging specimen collection. RN #1 stated laboratory turnaround time is typically four hours, and in her opinion, if a resident is suspected of being septic, laboratory testing should be obtained immediately rather than waiting until the next day. O. On [DATE] at 10:19 AM, during an interview, the Medical Director (MD) stated residents suspected of having sepsis should be closely monitored while awaiting laboratory results, including frequent assessments for changes in mental status, vital signs, and other signs of clinical deterioration. The MD stated residents would typically be assessed approximately every two hours. The MD stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laboratory tests ordered to evaluate suspected sepsis should be obtained the same day they are ordered or by the following morning. The MD stated laboratory testing should not take three days and should be completed the afternoon it is ordered or by the following morning. The MD stated R #2 and R #4's laboratory tests should have been completed sooner rather than after multiple days.

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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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 (R #4) of 1 (R #4) resident, when:The facility staff did not ensure a physician's order was accurate for administering Lactated Ringer solution (LR; an intravenous fluid used to replace lost fluids and electrolytes and help correct acid˜base imbalances), and the LR solution was not administered as expected in accordance with professional standards of practice.If ordered intravenous fluids are not administered as intended, residents may receive substandard care and treatment, placing them at risk for preventable harm. The findings are: A. Record review of the facility's intravenous fluid and drug administration policy, dated 10/2024, revealed the following:A licensed independent practitioner's order is required for all IV infusions. The nurse shall assess the appropriateness of the prescribed therapy, including the resident's condition, dose, route, and rate of the ordered solution or medication. The nurse shall monitor the resident for therapeutic response, recognize adverse reactions, implement nursing interventions as indicated, and provide ongoing monitoring.Prior to IV infusion, the nurse shall verify IV catheter patency (catheter being open, unobstructed, and functioning correctly, allowing fluids and medications to flow freely into the bloodstream without resistance) and flush (a medical procedure involving the injection of a sterile saline solution into an IV line) the IV catheter as ordered. B. Record review of R #4's face sheet revealed an admission date of 05/03/2026 and the following diagnoses: Acute Kidney Failure (a sudden loss of kidney function).Chronic Kidney Disease (CKD; impaired kidney function).Acute Respiratory Failure with Hypoxia (a condition in which the lungs suddenly cannot get enough oxygen into the blood). C. Record review of R #4's physician orders dated 05/20/2026 revealed the following:Active order for Lactated Ringer's Solution 250 mL (milliliters) IV every 30 minutes as needed for acute kidney injury and monitor for fluid volume overload. Check blood pressure and heart rate 30 minutes after each bolus (is a single, concentrated dose of medication or fluid administered rapidly into a vein for immediate therapeutic effect).Bolus may be repeated up to three times as directed by the provider and notify the provider if there was no response after the third bolus. D. Record review of R #4's Treatment Administration Record (TAR), dated 05/20/2026 through 05/31/2026, revealed R #4 was not administered a Lactated Ringer bolus as needed per physician orders during this timeframe. E. Record review of R #4's facility transfer form, dated 05/31/2026, revealed R #4 was transferred to the emergency room (ER) due to peripheral edema (swelling of the legs, ankles, and feet caused by excess fluid buildup), altered mental status, and hypotension (low blood pressure) in the presence of acute kidney injury. R #4's blood pressure (normal range 90/60 mmHg to 120/80 mmHg) was 94/68 mmHg before transfer to the hospital. F. On 06/29/2026 at 8:05 AM, during an interview, Nurse Practitioner (NP) #1 stated she ordered intravenous hydration with Lactated Ringer's solution for R #4, and a peripherally inserted central catheter (PICC line; a thin, flexible catheter inserted into a peripheral vein and guided to a large central vein near the heart to deliver medications, fluids, or nutrition over an extended period) was placed to administer the IV fluids. NP #1 stated the order was to administer one Lactated Ringer bolus, then reassess the resident's vital signs, laboratory results, clinical response, and monitor for fluid volume overload before determining whether additional boluses were needed. NP #1 stated the order allowed up to three boluses but was not intended for all three to be administered consecutively due to the resident's impaired kidney function. NP #1 stated R #4's Lactated Ringer IV administration should have been a scheduled treatment rather than ordered as needed, and the PICC line was placed to administer the ordered solution. G. On 06/29/2026 at 10:19 AM, during an interview, the Medical Director (MD) stated when a resident is borderline septic with hypotension and tachycardia (fast heart rate), he may order one liter of Lactated Ringer's solution to be administered rapidly. The MD stated failure to administer ordered intravenous fluids could contribute to a resident requiring a more rapid transfer to the hospital. The MD stated R #4's IV fluid orders should include clear instructions regarding the rate and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timing of administration and emphasized the importance of communication between providers and nursing staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews, the facility failed to ensure the environment was free of accident hazards for 2 (R #9 and #25) of 4 (R #5, #6, #9, and #25) residents, when the facility staff failed to:Ensure the residents' bed wheels were locked while the beds were in use to prevent falls.This deficient practice is likely to result in residents getting injured in avoidable accidents and putting residents at risk of serious injury and harm.The findings are: R #9: A. Record review of R #9's face sheet revealed an admission date of 05/28/25 with the following diagnoses: Muscle weakness and unsteadiness on feet.impaired gait (deviation from normal walking) and mobility issues.Chronic pain.Third degree burns (severe, full thickness burns that destroy all layers of the skin and underlying tissues, requiring immediate medical attention) with skin graft (a surgical procedure in which healthy skin is taken from one part of the body and transplanted to cover an area of damaged or missing skin).Right foot drop (cannot lift the front part of the foot due to weakness or paralysis of the muscles). B. Record review of R #9's nursing progress notes, dated 06/19/26, revealed at 12:09 PM a Certified Nursing Assistant (CNA) was notified that R #9 was on the floor. When the nurse entered R #9's room, R #9 was sitting on the floor next to her bed. The room was dark, R #9's walker was pushed to the left side, the bed wheels were unlocked, and the bed had shifted from its normal position. C. Record review of R #9's nursing progress notes, dated 06/25/26, revealed at 3:15 am, R #9 reported she fell while getting out of bed to reach her wheelchair to go to the bathroom. D. On 06/25/26 at 1:00 pm, during an observation, R #9 was leaving the bathroom and returning to her bed. R #9's bed wheels were unlocked, and she needed assistance to lock the wheels so she could safely get into bed. E. On 06/25/26 at 1:03 pm, during an interview, R #9 stated there had been a few times when she went to sit back down on the bed and the bed slid because the wheels were unlocked, which resulted in her falling. R #9 stated her bed wheels seemed to be unlocked frequently, and she did not know who was unlocking her bed. F. On 06/25/26 at 1:15 pm, during an interview, CNA #6 stated there was no reason for CNAs to unlock the brakes on residents' beds. She stated housekeeping staff will unlock the beds at times to clean underneath them, but the wheels should be locked afterward. R #25: G. On 06/26/26 at 8:15 am, during an observation, R #25 was lying in bed asleep with the bed wheels unlocked. H. On 06/26/26 at 8:25 am, during an interview, Registered Nurse (RN) #8 stated R #25's bed wheels should be locked, especially when the resident is lying in the bed. RN #8 stated unlocked bed wheels could contribute to resident falls. She stated both CNAs and housekeepers will unlock and move beds as needed, but they should lock the wheel brakes when they finish moving the bed. I. On 06/29/26 at 3:30 pm, during an interview, the Director of Nursing (DON) stated R #9's last fall on 06/25/26 occurred because the bed wheels were not locked. The DON stated the bed wheels for R #9 and R #25 should be locked at all times when the beds are in use.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interviews, the facility failed to ensure 1 (R #16) of 1 (R #16) resident received necessary behavioral health care to meet their needs, when staff failed to refer them for behavioral health services after they experienced depression symptoms and voiced self^harm statements. This deficient practice is likely to result in worsening behaviors and failure to receive the behavioral or mental health care needed to improve mood and reduce depression and anxiety. The findings are: A. Record review of R #16's face sheet revealed an admission date of 03/11/25 with the following diagnoses:Major depressive disorder (is a common and serious mental illness that affects your mood and interest in life).Parkinson's disease (is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves).Macular degeneration (causes reversible vision loss).Alzheimer's disease (is a type of dementia that affects memory, thinking and behavior).Anxiety disorder (persistent and excessive distress that affects daily life). B. Record review of R #16's care plan, dated 02/15/26, revealed R #16 experienced distressed, fluctuating mood symptoms related to sadness, depression, changes in relationships, and personal loss. Facility staff are to refer R #16 to behavioral health as needed. C. Record review of R #16's change in condition (CIC; new, different, or worsening sign, symptom, or behavior in a resident that deviates from their established baseline or expected pattern of health and function) progress note, dated 04/20/26, revealed R #16 was seen by Certified Nursing Assistant (CNA) crying in his room stating that he wants to die because he has no friends. R #16 then left his room and stated he wanted to die because he had no friends, could not leave the facility, and felt like it was a prison. The provider was notified. D. Record review of R #16's electronic health record (EHR), dated 06/29/26, revealed R #16 was not referred to behavioral health services for talk-therapy after the statement he made on 04/20/26. The EHR did not contain physician orders or communication indicating R #16 should be referred to a behavioral health services provider for talk-therapy. E. On 06/29/26 at 1:00 pm, during an interview, Director of Nursing (DON) stated she was not aware of R #16's statements made on 04/20/26. The DON stated the facility prescribed R #16 antidepressant medication in response to his depression and suicidal (self-harm) statements, but talk-therapy was not requested and should have been, since it was an approved service. F. On 06/29/26 at 1:53 pm, during an interview, the out-of-facility Nurse Practitioner (NP) #3 stated R #16 was seen by an out^of^facility provider on 04/21/26, and his medications for depression and anxiety were increased slightly. She stated the message she received from the facility on 04/20/26 did not indicate that R #16 was feeling suicidal and only reported increased loneliness and anxiety. She stated if a resident voices being suicidal, an assessment is completed to determine the severity of those thoughts, and a referral for behavioral health services would be made if suicidal ideation is reported. NP #3 stated a behavioral health talk^therapy referral should have been made for R #16 after his statements on 04/20/26, but this did not occur.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interviews, the facility failed to ensure a resident did not receive unnecessary painˆmanagement medications for 1 (R #6) of 1 (R #6) resident. This deficient practice is likely to lead to unwanted drug effects and poor patient outcomes. The findings are: A. Record review of R #6's face sheet revealed an admission date of 05/12/26 and a discharge date of 05/29/26, with the following diagnoses:Acute osteomyelitis (infection in the bone) of the right ankle.Fracture of shaft of left clavicle (left shoulder fracture). B. Record review of R #6's care plan, dated 05/13/26, revealed R #6 is at risk for substance use (refers to the consumption of alcohol, tobacco, prescription medications, or illicit drugs, which may lead to negative physical, mental, or social consequences) related to a history of addiction. C. Record review of R #6's hospital medication summary, dated 05/12/26, revealed R #6 was to receive the following medications upon discharge from the hospital: Buprenorphine-naloxone (suboxone; a combination medication used to treat opioid/narcotic addiction) 4 milligram (MG), one sublingual film (a thin, dissolvable strip of medication placed under the tongue to allow rapid absorption directly into the bloodstream) every 4 hours.Lidocaine topical (used to relieve localized nerve pain by numbing the affected area), two patches every 12 hours for pain. Methocarbamol (muscle relaxant used to relieve pain and discomfort from acute musculoskeletal conditions) 750 mg, three times per day. D. Record review of R #6's physician orders revealed the following:Dated 05/13/26, Buprenorphine HCl-naloxone, sublingual Film 4 mg. Give one film sublingually four times a day for opioid use disorder (OUD). This medication was discontinued on 05/18/26. Dated 05/14/26, Oxycodone HCl (used to manage pain severe enough to require an opioid pain medicine when other pain medicines do not treat pain well enough or are not tolerated) extended release (ER) tablet 12-hour abuse-deterrent 10 mg. Give one tablet by mouth every 12 hours for moderate to severe pain for 14 days. This medication was discontinued on 05/27/26.Dated 05/18/26, Buprenorphine HCl-naloxone, sublingual Film 4 mg. Give one film sublingually four times a day for opioid use disorder (OUD). This medication was discontinued on 05/25/26. Dated 05/25/26, Buprenorphine HCl-naloxone, sublingual Film 4 mg. Give one film sublingually every four hours for pain for three days. Dated 05/27/26, Oxycodone HCl ER tablet 12-hour abuse-deterrent 10 mg. Give one tablet by mouth every 12 hours for moderate to severe pain. Do not exceed two tablets within 24 hours. E. On 06/24/26 at 12:05 pm, during an interview, the Director of Nursing (DON) stated the suboxone prescriptions are reviewed by Physician #1, who oversees a methadone (a long-acting opioid medication that is used to reduce withdrawal symptoms in people addicted to heroin or other narcotic drugs) clinic. The DON stated methadone is given only in the clinic and Suboxone is delivered to the facility and administered to residents as ordered. The DON stated she has questioned why some residents are being given Suboxone and oxycodone together, as in R #6's case, because Suboxone can block the intended effects of oxycodone. F. On 06/29/26 at 10:00 am, during an interview, the Medical Director (MD) stated he works closely with Physician #1 and is highly involved in the care of residents in the facility, but he does not prescribe Suboxone or oxycodone. The MD stated residents who take Suboxone would need high amounts of oxycodone to receive pain relief. He stated a dose of 20 to 30 milligrams of oxycodone would be needed to override the Suboxone's effects, and a 10ˆmilligram dose would provide only a placebo effect (a phenomenon where a person experiences real improvement in health or symptoms after receiving a treatment that has no therapeutic effect, driven by their expectations or beliefs). The MD stated even if oxycodone does not provide adequate pain control, it will calm their [resident's] mind.