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	05/05/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52440 Based on record review and interview, the facility failed to ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and lifesaving care) was properly documented for 1 (R #42) of 1 (R # 42) resident reviewed for advance directives. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #42's face sheet, undated, revealed the following: - admitted [DATE]. - Advanced directive was Do Not Resuscitate [DNR; does not want to have cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation) performed if their heart or breathing stops.] C. Record review of R #42's New Mexico Medical Orders For Scope of Treatment (MOST), dated [DATE], revealed R #42 advanced directive was a Full Code (desired life saving procedures, such as CPR.) D. On [DATE] at 02:58 PM during an interview with Unit Manager (UM) #1, she stated R #42's code status should be Full Code and not DNR. UM #1 stated staff completed an audit of residents' advance directives in [DATE]. She stated R #42's code status was changed to Full Code on the MOST form but was not updated in R #41's medical records to reflect the Full Code status.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on observation, record review, and interviews, the facility failed to maintain a clean, safe, and comfortable environment for residents when staff failed to: 1) Repair damaged and broken blinds in resident rooms #103, #109, #206, #305, #309, and #311. 2) Repair broken wall tiles in resident bathrooms in rooms #103, #106, and #107. 3) Paint over unpainted drywall in resident rooms #101, #102, #103, #107, #302, #303, and #305. 4) Clean dust from ceiling fans above the dining room eating area. 5) Replace stained tablecloths in the dining room. 6) Ensure the cleanliness of vending machines in the common area. 7) Maintain the conference room in a clean, uncluttered, and hazard-free condition. 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. These deficient practices could likely result in residents feeling frustrated, embarrassed, and unimportant. The findings are: Broken Blinds A. On 04/28/25 at 10:00 A.M., during an observation, resident rooms #103, #109, #206, #305, #309, and #311 had broken blinds. B. On 05/02/25 at 2:00 P.M., during an interview, the Maintenance Director (MD) stated he was aware of some of the broken blinds in resident rooms. He stated he only checked a few rooms for maintenance issues because of time constraints. He said staff were expected to submit work orders when they noticed broken blinds. He stated he did not routinely inspect resident rooms for damaged fixtures, such as blinds. Resident Shower Rooms C. On 04/28/25 at 10:00 A.M., during an observation, the following resident rooms had missing wall tiles in the showers: - room [ROOM NUMBER] was missing 11 wall tiles. - room [ROOM NUMBER] was missing six wall tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER] was missing eight wall tiles. D. On 05/02/25 at 2:00 P.M., during an interview, the MD stated he was not aware of the broken tiles in the bathrooms of Rooms #103, #106, and #107. He stated he only had time to check a few rooms each week for general maintenance issues but could not provide a schedule or system for those checks. He said staff were expected to submit work orders for any needed repairs, including broken tiles. He stated he did not routinely enter resident rooms to inspect for damage unless staff submitted a work order. Unpainted Walls E. On 04/29/25 at 8:32 A.M., during an observation of the 100 and 300 units, seven resident rooms (#101, #102, #103, #107, #302, #303, and #305) had areas of unpainted drywall mud on the walls. The unpainted drywall mud was not painted to match the surrounding wall surfaces and gave the appearance of incomplete repair work. F. On 05/02/24 at 2:15 P.M., during an interview, the MD stated he did not get to the unfinished and unpainted room walls, because he was busy. Dining Room G. On 04/30/25 at 12:41 P.M., during an observation of the dining area, three ceiling fans located above the residents' eating area had visible dust buildup on the fan blades. H. On 05/02/25 at 3:02 P.M., during an interview, the Housekeeping Staff (HS) stated she expected staff to clean the ceiling fans in the dining area monthly. She stated she could not recall when staff last cleaned the fans. She stated dust from the fans could fall onto residents and their food if staff did not clean the fans regularly. Tablecloths in Dining Room I. On 04/29/25 at 10:36 A.M., during an observation of the dining room, the tablecloths on the tables had a strong odor and were stained with cup rings and other stains. J. On 05/02/25 at 3:00 P.M., during an interview,the HS stated she asked for new tablecloths for the dining room, but she did not receive them yet. She stated she expected the tablecloths to be odor free and without stains. Vending Machine K. On 04/30/25 at 12:43 P.M., during an observation, the dining area contained two vending machines. Further observation revealed the tops of the vending machines were dusty. Several used white Styrofoam cups and eight smashed soda cans sat on top of the dusty vending machines. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. On 04/30/25 at 3:02 P.M., during an interview, the HS stated she did not realize the tops of the vending machines were dirty. She stated the housekeeping team did not have a routine system in place to check or clean the tops of the vending machines. She stated her Supervisor expected staff to maintain all visible and non-visible surfaces in a clean condition, but the tops of the vending machines were not part of the daily or weekly cleaning checklist. Conference Room M. On 04/28/25 at 10:41 am, during an observation, the sink in the conference room had a container under the sink drain. Further observation revealed the container was full to the top with black water which had a strong odor. N. On 04/28/25 at 10:42 am during an interview, the Administrator (ADM) confirmed the container of black water with a strong odor was located under the sink in the conference room. The ADM stated the conference room was utilized for resident Care Plan meetings, and residents and family members attended the Care Plan meetings in the room. The ADM stated the standing water with an odor was not acceptable. 50752

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment of a resident's functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 1 (R #42) of 1 (R #42) resident reviewed for MDS assessments. This deficient practice could result in failure to provide adequate care and treatment of the resident's needs. The findings are: A. Record review of R #42's face sheet revealed an admitted [DATE] and included the following diagnoses: - Alcohol use, unspecified with alcohol-induced persisting amnestic (memory deficit). - Cognitive functions and awareness. -Alcohol abuse. B. Record review of R # 42's MDS, dated [DATE], revealed the following: - Brief Interview for Mental Status (BIMS; screening for cognitive impairment) score of 14, moderately impaired cognition. - The resident did not have an acute change in mental status from resident's baseline (starting mental status.) - The resident sometimes understood and sometimes understands. C. Record review of R #42's MDS, dated [DATE], revealed the following: - BIMS score of 15, intact cognition. - The resident did not have an acute change in mental status from resident's baseline. - The resident usually understood and sometimes understands. D: Record review of R #42's progress notes, dated 03/15/25 and completed by the Doctor of Nursing Practice (DNP), revealed the following: - The resident had a quarterly psychiatric follow-up for Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior), onset unknown. - The resident was oriented to person and place. Partial impairment regarding time and mild-to-moderate memory deficits. Demonstrated partial recall of information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	E. On 05/02/25 at 02:46 pm, during an interview, MDS Coordinator I stated both MDSs were correct because the resident changed during the three month period. MDS Coordinator I stated she verified the completion of the MDS sections, but she was not responsible for the accuracy of the MDS. F. On 05/02/25 at 3:05 pm, during an interview with the Social Services Director, she stated R #42's MDS dated [DATE] was coded incorrectly. The Social Services Director stated R #42's MDS appeared to contradict the information in the resident's record and was inaccurate. The Social Services Director stated R #42 understands when people speak to him. The Social Services Director stated MDS Coordinator I and II were responsible for the review and accuracy of the residents' MDS. 52440

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observation, record review, and interview, the facility failed to ensure staff revised the care plans for 2 (R #7 and R #24) of 2 (R #7 and R #24) residents reviewed. Staff failed to update the care plans to reflect each resident's current needs regarding the use of appropriate utensils during mealtime. Appropriate utensils refer to those assessed as safe and suitable for the resident based on their physical and mental condition (e.g., plastic utensils instead of metal for residents with a history of self-harm). If care plans are not updated to reflect residents' current needs, then staff may provide inappropriate items or assistance, which could result in unmet care needs and safety risks. The findings are: R #7 A. Record review of R #7's face sheet revealed an admitted [DATE] with the following diagnoses: - Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), -Muscle weakness (reduction in the power exerted by muscles.) B. Record review of R #7's Care Plan, dated 03/04/25, revealed the resident to use plastic utensils for eating. C. On 04/29/25 at 12:55 P.M., during an observation, R #7 sat in the dining room with staff and ate his lunch. R #7 ate lunch with a metal fork. D. On 05/02/25 at 10:00 A.M., during an interview, the Administrator stated R #7 had a history of suicidal thoughts but had not exhibited such thoughts for several years. She stated she was confident the facility could manage any concerns related to his mental health. She explained R #7 was currently permitted to use metal forks and spoons. She stated care plan meetings were held quarterly (every 90 days), but staff did not update R #7's care plan. She stated it was her expectation that staff review and update each resident ' s care plan at least every quarter. E. On 05/02/25 at 10:40 A.M., during an interview, the Director of Nursing (DON) stated staff did not revise R #7's care plan and remove that the resident had to use plastic utensils. She stated it was her expectation for staff to review and update resident care plans quarterly. R #24 F. Record review of R #24's face sheet revealed an admitted [DATE] with a diagnosis of dementia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 04/29/25 at 12:25 P.M., during an observation, R #24 ate his lunch alone in the dining room while staff served meals to the other residents. R #24 ate his pureed lunch with a regular-sized teaspoon. R #24 coughed and cleared his throat. Staff told the resident to take a drink, and R #24 continued to eat. H. Record review of R #24's Care Plan, dated 04/30/25, revealed staff were directed to do the following: - Provide a small spoon for meals. - Provide assistance during meals. - Encourage small sips and bites and cue as needed. - Encourage resident to chew and swallow each bite. - Encourage resident to alternate liquids and solids. - Encourage resident to perform double swallows. - Encourage small sips and bites and cue as needed. - Monitor for sign and symptoms of aspiration (sucking food into the airway.) I. On 05/02/25 at 9:55 A.M., during an interview, the Speech-Language Pathologist (SLP) stated R #24 was on a pureed diet (a texture modified diet that requires no chewing), because he choked on the chewable food. She stated she did not receive any new updates about his choking issues since the resident switched to pureed foods. She stated the resident managed well with the pureed diet and did not need constant staff supervision while in the dining room. She stated staff should have updated the resident's care plan when R #24 switched to pureed food to state the resident could use a regular size spoon. She stated she did not recall when the puree diet was changed. She stated she did not have anything to do with resident care plans. J. On 05/02/25 at 10:00 A.M., during an interview with the Administrator, she stated R #24 could have a regular sized spoon since he switched to a pureed diet. She stated they reviewed R #24's nourishment care area in the resident's care plan, but they missed the spoon section. She stated the spoon was listed under activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating.) She stated it was her expectation for staff to review and update all resident care plans quarterly. K. On 05/02/25 at 10:40 A.M., during an interview, the DON stated staff did not revise R #24's care plan was for the use of a regular spoon while eating. She stated it was her expectation for staff to review and update all resident care plans quarterly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review, observation, and interview, the facility failed to ensure a safe environment free of the potential for accidents and hazards for all residents when staff failed to: - Ensure accurate smoking supervision assessments were completed for R #7; - Ensure residents did not have lighters in their rooms; - Ensure staff did not store personal belongings in resident rooms; - Prevent unsecured bleach cleaning wipes from being left in resident bathrooms. This deficient practice placed residents at risk for burns, fire-related injuries, chemical exposure, and ingestion of unsafe substances. The findings are: R #7 A. Record review of facility's Smoking Safety policy, dated 04/10/24, revealed all smoking supplies (to include tobacco, matches, lighters, and lighter fluid) must be labeled with the resident's name, room number, and bed number; maintained by staff; and stored in a suitable cabinet at the nurses station. Lighters are not permitted in resident rooms due to fire risk, especially when oxygen is in use. B. Record review of R #7's face sheet revealed an admitted [DATE], with the following diagnoses: -Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). -Muscle weakness. C. Record review of R #7's smoking assessments revealed the following: conflicting documentation regarding the resident's need for supervision: - Dated 01/02/25, R #7 had dementia and required supervised smoking. - Dated 04/04/25, R #7 had dementia and could to smoke independently (without supervision.) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 05/02/25 at 1:18 P.M., during an interview with the Director of Nursing (DON), she stated R #7 had dementia, and staff were expected to supervise the resident while he smoked. She stated smoking assessments were completed quarterly. She stated she expected staff to assess residents with dementia appropriately and to monitor them during smoking activities. She stated it was hazardous for a resident with dementia to smoke unsupervised. The DON stated it was her responsibility to ensure smoking assessments were completed accurately. Lighter in Rooms E. Record review of the facility's Smoking Policy, dated 04/10/24, revealed smoking supplies (to include tobacco, matches, lighters, and lighter fluid) will be maintained by staff and stored in a suitable cabinet at the nursing station. F. On 04/29/25 at 1:33 P.M., during an observation of a resident room in the 200 unit, a resident sat on his bed and held a green lighter in his hand. G. On 04/29/25 at 2:30 P.M., during an interview, the Administrator stated lighters were not permitted in resident rooms due to the risk of fire. She stated staff were expected to retrieve lighters for residents from the nurses' station and ensure residents returned them promptly after smoking. She stated nursing staff were responsible to ensure residents did not retain lighters in their possession. The Administrator also stated staff routinely swept the halls to check for lighters, but she did not specify the frequency of these checks. H. On 05/01/25 at 11:23 A.M., during an observation of the 100 hall, a blue lighter sat on a resident's bedside table in an occupied room. I. On 05/01/25 at 12:05 P.M., during an interview, Unit Manager (UM) #1 stated staff attempted to confiscate lighters from all residents but sometimes residents refused. She stated staff documented when residents refused and attempted to retrieve the lighter later. She stated lighters posed multiple hazards, to include burns, risk of fire, and increased danger due to oxygen use in the building. She stated she confiscated three lighters from different residents earlier that day. J. On 05/01/25 at 1:10 P.M., during an interview, the Director of Nursing (DON) stated she was not aware staff found lighters in residents' rooms. She stated residents were not supposed to retain lighters. She stated some residents used oxygen in the facility and that increased the danger of fire. She stated lighters in resident rooms violated facility policy and posed a serious risk. Staff belonging in resident room K. On 05/01/25 at 3:00 P.M., during an observation of a resident's room, the room was furnished for two residents, but only one resident lived in the room. Further observation revealed a staff purse, a duffle bag, and a grey sweater in the unoccupied closet. L. On 05/01/25 at 3:45 P.M., during an interview, UM #1 stated staff personal belonging should not be in the resident rooms. She stated many hazards could happen if the resident got into the staff's belongings (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 05/02/25 at 10:30 A.M., during an interview, the Administrator stated staff was expected to store personal items in the staff break room. She stated staff were never permitted to leave belongings in residents' rooms. She stated residents could access and take items that did not belong to them, including food or drinks that were not part of their dietary plan. Bleach Wipes N. On 05/01/25 at 10:23 A.M., during an observation of resident room [ROOM NUMBER], a container of bleach wipes sat on the bathroom sink. Further observation revealed the container of bleach wipes did not have a top, and the wipes in the container were exposed. O. On 05/02/25 at 2:14 P.M., during an interview, Certified Nursing Assistant (CNA) #12 stated bleach wipes should not be left in resident bathrooms. She stated she did not know the potential hazards of leaving the wipes accessible. P. On 05/02/25 at 2:30 P.M., during an interview, UM #1 stated staff should not leave wipes in any resident bathroom. She stated the resident could mistake the bleach wipes for personal wipes and misuse them.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35632 Based on observation, interview and record review, the facility failed to date the oxygen tubing for 1 (R #325) of 1 (R #325) residents reviewed for oxygen. If the facility is not dating and initialing the oxygen tubing and humidifiers (provide moisture when delivering oxygen) then staff may be unaware as to when the tubing and humidifier should be changed and could cause the tubing to become dirty leading to reduced oxygen flow. The findings are: R #325 A. Record review of R #325's physician orders, dated May 2025, revealed the following: - Oxygen at 2 liter (L) per minute via nasal cannula (a device that delivers extra oxygen through a tube and into your nose), continuously. Every day and night shift. Start date 05/02/25. - Oxygen tubing change weekly. Label each component with date and initials. Start date 05/02/25. B. On 05/02/25 at 12:08 pm, during an observation, R #325's oxygen tubing and humidifier bottle did not have the staff initials or date. C. On 05/02/25 at 12:18 pm, during an interview with Certified Nursing Assistant (CNA) #8, she confirmed staff did not label R #325's oxygen tubing and the humidifier bottle with a date and staff initials. CNA #8 stated staff should label and date each component on admission and anytime they changed the humidifier bottle. D. On 05/02/25 at 3:27 pm, during an interview with Unit Manager #1, she stated staff should date and initial oxygen tubing and humidifier bottles on admission and when staff replaced them.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51919 Based on observations, interviews and record review, the facility failed to ensure Nurses and Certified Medication Aides (CMAs) dated opened insulin (a medication prescribed to help the body turn food into energy and manages blood sugar levels) pens and discarded them within 28 days of the opening date for 5 (R #5, R #27, R #47, R #71, R #82) of 5 (R #5, R #27, R #47, R #71, R #82) residents reviewed. This deficient practice is likely to result in all five residents receiving medications that are less effective or expired. The findings are: A. Record review of the facility's Medication Storage Policy, dated [DATE], revealed the following: - Note the date on the label for insulin vials and pens when first used. - The policy did not address discarding insulin pens within 28 days of opening. B. Record review of the manufacturer's instructions for Insulin Glargine multiple dose vial, dated 2022, revealed staff were instructed to throw away all opened vials after 28 days of use, even if there was insulin left in the pen. C. Record review of the manufacturer's instructions for Insulin Lispro multiple dose vial, dated 2023, revealed staff were instructed to throw away all opened vials after 28 days of use, even if there was insulin left in the pen. D. Record review of the manufacturer's instructions for Insulin Aspart multiple dose vial, dated 2023, revealed staff were instructed to throw away all opened vials after 28 days of use, even if there was insulin left in the pen. E. On [DATE] at 10:04 am, observation of the 100 Hall medication cart revealed the following: - Insulin Lispro (a short-acting insulin),100 units/milliliter (ml) multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #5. - Insulin Lispro ml multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #27. - Insulin Lispro 100 units/ml multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #47. - Insulin Glargine (a long-acting insulin),100 units/ ml multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #71. - Insulin Lispro 100 units/ ml multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #71. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Insulin Aspart (a short-acting insulin),100 units/ ml multiple-dose pen was opened and dated [DATE]. The insulin pen belonged to R #82. F. Record review of R #5's Physician Orders, revealed an order for Insulin Lispro. Start date [DATE], stop date [DATE]. G. Record review of R #27's Physician Orders, revealed R #27 had an order for Insulin Lispro. Start date [DATE], stop date [DATE]. H. Record review of R #47's Physician Orders, revealed R #47 had an order for Insulin Lispro. Start date [DATE], stop date [DATE]. I. Record review of R #71's Physician Orders, revealed R #71 had the following orders: - Insulin Glargine. Start date [DATE], stop date [DATE]. - Insulin Lispro. Start date [DATE], stop date [DATE]. J. Record review of R #82's Physician Orders, dated [DATE], revealed R #82 had an active order to receive Insulin Aspart. K. On [DATE] at 2:06 pm, during an interview, Nurse #2 stated he should have discarded the opened insulin pens within 28 days of the opening date. L. On [DATE] at 2:45 pm, during an interview, 100 Hall Unit Manager (UM) #2 stated staff must date the opened insulin pens and discard them within 28 days of the opening date. She stated she expected Nurses and CMAs to check the insulin pens for labeleing when they start thier shifts and discard them after 28 days. M. On [DATE] at 12:56 pm, during an interview, the Director of Nursing (DON) stated staff must date the opened insulin pens and discard them within 28 days of the opening date. She stated Nurses and CMAs are trained on insulin pen labeling. She stated she expected Nurses and CMAs to label the insulin pens when they first open them and discard them after 28 days, even if there was still insulin inside them. N. On [DATE] at 10:20 pm, during an interview, the facility's Consultant Pharmacist (CP) #1 stated she expected Nurses and CMAs to date the opened insulin pens and discard them within 28 days of the opening date. He stated after 28 days of opening insulin pens they are considered expired.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52440 Based on record review observation and interviews, the facility failed to ensure residents obtained routine dental care for 2 (R #15 and R #48) of 2 (R #15 and R #48) residents reviewed for dental services. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition/appearance of teeth, and potential dental or oral complications. The findings are: R # 15: A. On 04/28/25 at 12:15 PM, during an observation and interview, R #15 did not have visible teeth or dentures. R #15 said she needed to be seen by the dentist, because her dentures did not fit properly. B. Record review of R #15 Oral Health Evaluation, dated 12/10/23, revealed R #15 was at risk for oral health and dental care problems. R #15's last dentist appointment was on 08/22/22. The resident required an follow-up dental appointment for proper fitting dentures. C. Record review of R #15's Electronic Health Record (EHR) revealed the following - Physician order, dated 11/14/24, dental referral. - R #15 did not have a follow-up dentist appointment. R #48: D. On 04/28/25 at 11:57 am, during an observation and interview, R #48's front teeth appeared decayed. R #48 stated he had not seen the dentist since before his admission. E. Record review of R #48's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/28/24, revealed an admitted [DATE]. F. D. Record review of R #48's Oral Health Evaluation, dated 05/17/23 revealed #48 was at risk for oral health and dental care problems. G. Record review of R #48's care plan, dated 03/14/24 revealed the resident was at risk for oral care or dental care problems. H. Record review of R #48's physican progress note, dated 04/01/25, revealed the resident had bleeding gums. I. Record review of R #48's EHR revealed the following - An order, dated 09/26/22, dental referral. - R #48 did not have a dentist appointment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J. On 05/02/25 at 3:27 PM, during an interview, Unit Manager (UM) #1 stated R #15 did not see a dentist since 08/22/22. She stated R #48 did not see a dentist since 08/22/20 (admission.) UM #1 stated all residents should see the dentist annually. UM #1 stated she was responsible for the audit of dental appointments, and the facility had issues findiung consistent dental providers.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40671 Based on observation, record review, and interview, the facility failed to ensure the nutritional needs and preferences were met for all 118 residents listed on the facility census provided by the Administrator on 04/28/25 when staff failed to: 1. Serve the food items listed on the menu. 2. Provide residents with the opportunity to select their choice from the menu or alternate menu in advance of meal service. If the facility is not providing meal as listed on the menu or offering residents the option to select their choice of meal in advance of meal service, then residents are likely to experience frustration, depression, weight loss, and feel unimportant. The findings are: A. Record review of posted lunch menu for 04/30/25 revealed the following:- Main menu item was sausage pizza with marinated cucumber salad. - Alternate menu item was crispy breaded chicken, corn with fresh herbs, and a dinner roll with margarine. - Dessert was a peanut butter cookie. B. On 04/30/25 at 12:24 pm, an observation of the lunch meal service revealed staff served R #19 a cubed pork with peppers sandwich instead of the pizza on the menu. C. On 04/30/256 at 12:25 pm during an interview, R #19 stated, I am tired of this shit. They (facility staff) constantly serve me stuff that is not on the menu. She stated she was often served meals that were not a complete meal or something that was not on the menu. R #19 stated she was tired of being served the wrong food. She stated that she reported the many issues with the food service to everyone she could from the Certified Nurse Aides (CNAs) to the dietary staff and nothing changes. D. On 04/30/25 at 12:29 pm during an interview, the Corporate Chef (CC) stated he did not know why R #19 was served a cubed pork with peppers sub sandwich instead of the pizza on the menu. He stated maybe it was because R #19 had a dairy allergy, and there is cheese on pizza. CC stated he did not know why she was served something that was not on the menu for today or the alternate menu. E. On 05/01/25 at 10:48 am during an interview, R #19 stated staff served her two pieces of toast on a plate with nothing else. She stated her roommate received eggs but did not like them. She stated her roommate gave her the eggs. R #19 stated she was tired of it. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. On 05/02/25 at 10:29 am during an interview, the Dietary Manager (DM), she stated staff did not ask residents in advance what they preferred from the daily menu. She stated there was a book with resident room numbers, what their meal preferences were, and which staff member the resident told about their preferences. The DM stated the facility chose what meals to substitute, and the residents did not know in advance what the substitution would be. She stated it was not their usual process to have residents select their meals in advance. The DM stated if a resident did not like what was served, then they can send it back to the kitchen and request something off the alternate menu. She further stated that the residents were aware they could order something off the alternate menu if they preferred.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40671 Based on observation and interviews, the facility failed to ensure food was stored, prepared, and served under sanitary conditions when they failed to: - Ensure food was stored in a manner to prevent cross contamination and outdated use. - Maintain the kitchen in a clean and sanitary manner. - Ensure employees wore hair restraints. - Ensure staff did not serve drinks with their hands on the rim of the cup. This deficient practice could likely affect all 118 residents identified on the resident census list provided by the Administrator on 04/28/25. If food was not stored, prepared, and served under sanitary conditions then residents are at an increased risk of contracting food born illness, having weightloss, and may feel unimportant. The findings are: Food Storage A. On 04/28/25 at 9:53 am, an observation of the facility's kitchen revealed the walk-in refrigerator contained three large serving trays with uncovered, unlabeled, and undated beverages. B. On 04/28/25 at 9:55 am during an interview, the Corporate Dietary Manager (CDM) stated there should not be any uncovered, unlabeled, and undated foods or beverages in the refrigerator. C. On 05/01/25 at 11:54 am observations of the kitchen revealed the following: - Unlabeled and uncovered bowls of pudding and cups of orange, apple, and cranberry juice sat on serving trays in the refrigerator. - A box of flour open to air. - Two empty and visibly dirty pitchers sat on a serving tray with two other pitchers that contained orange juice and cranberry juice. Dated 04/26/25. D. On 05/02/25 at 10:29 A.M., during an interview with the Dietary Manager (DM), she stated there should not be any unlabeled, undated, or uncovered food or beverages in the refrigerator. Cleanliness E. On 04/28/25 at 9:53 am, an observation of the facility's kitchen revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was an uncovered storage bin that contained various crumbs on a storage shelf. - The wall over a storage shelf was covered with dead bug remains from the bug zapper (device used to kill pests) on the same wall.- There was trash on the floor of the walk in refrigerator.- Ice machine was dirty on the outside with hard water build up and water spots. F. On 04/28/25 at 9:55 am during an interview, the CDM stated the outside of the ice machine appeared dirty and should be clean. She further stated that there should not be anything on the refrigerator floor. G. On 05/01/25 at 11:54 am observations of the kitchen revealed the following: - A dirty wash rag sat on the shelf next to the clean dishes. - A ceiling vent covered with a black substance. The black substance was also on the ceiling and wall near the vent. - Crumbs on top of the dishwasher. - A white dusty substance covered unopened canned goods in the dry storage. Staff not wearing hairnets H. On 04/28/25 at 12:33 P.M., observation revealed dietary staff served food in the kitchen and did not wear a hair net or beard net. The staff had hair longer than 1/4 inch on his head and face. I. On 04/30/25 at 07:35 A.M., observation revealed a dietary staff served food and was not wearing a hair net or beard guard. The staff had hair longer than 1/4 inch on his head and face. J. On 05/02/25 at 10:29 A.M., during an interview with the Dietary Manager (DM), she stated staff should be wearing hair nets and beard guards while working in the kitchen. Meal Service K. On 04/29/25 at 12:16 pm, during observations of meal service staff grabbed resident drinks with their bare hands on the rims of the cup and served the drinks to the residents for lunch. L. On 04/30/25 12:11 P.M., during observations of meal services in the main dining room, staff grabbed resident drinks with their bare hands on the rims of the cup and served the drinks to the residents for lunch. -04/30/25 12:13 P.M. H. On 05/02/25 at 10:29 A.M., during an interview with the Dietary Manager (DM), stated staff should not grab resident drinks by the rims of the cup when they serve the drinks to the resident. 50752

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 40671 Based on observation and interview, the facility failed to ensure all garbage and refuse containers had lids or were covered when not in use. This deficient practice could likely affect all 118 residents identified on the resident census list provided by the Administrator on 04/28/25. This deficient practice could likely result in the unintentional sheltering and feeding of pests. The findings are: A. On 04/28/25 at 9:23 am during an observation, the kitchen the garbage dumpster, located outside the back entrance of the kitchen, was full of garbage, uncovered, and not in use. B. On 05/02/25 at 10:01 am during an observation, the outside dumpster contained garbage, uncovered, and not in use. C. On 05/02/25 at 10:08 am during an interview, the Maintenance Director (MD) stated staff place all facility garbage, to include the kitchen trash, in the dumpster located outside the back entrance to the kitchen. D. On 05/02/25 at 10:29 A.M., during an interview, the Dietary Manager (DM) stated all garbage containers should be closed or covered. She stated it was the kitchen staff's responsibility to make sure the garbage cans covered and the dumpsters were closed. She she stated an open dumpster could welcome animals to get into the dumpster.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 51919 Based on interviews and record reviews, the facility failed to provide complete documentation of an infection surveillance plan (ISP, a system for tracking and monitoring infections) for identifying, tracking, monitoring, and reporting of infections, communicable diseases (an illness that can spread from one person to another), and outbreaks (the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time) among residents and staff. This failed practice has the potential to affect all 118 residents in the facility. This deficient practice is likely to lead to a higher risk of patient harm, difficulty identifying and addressing outbreaks, and difficulty tracking the effectiveness of infection prevention measures (basic practices to stop the spread of germs). The findings are: A. Record review of the facility's Infection Prevention and Control Program (IPCP) documentation, undated, revealed it did not include the following: - A procedure on how staff monitored residents to identify possible infections and communicable diseases. - Early detection and management of a potentially infectious, symptomatic residents that required laboratory testing and the implementation of appropriate transmission-based precautions (TBP, used to prevent the spread of infectious agents from individuals who are suspected to be infected. Includes contact precautions, droplet precautions, and airborne precautions. Examples are wearing gloves, face masks, and gowns or using disposable equipment) and personal protective equipment (PPE, protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) and tracking this information in an infectious disease log. - Evidence-based surveillance (making decisions about care, education, or management by using the best available research evidence, along with own expertise and the unique circumstances of the individual or situation) to define infections and the use of a data collection tool (instruments used to gather, organize, and store data from various sources). - Ongoing analysis of surveillance data and documentation of follow-up activity in response. B. On 04/30/25 at 12:20 pm, during an interview, the facility's Administrator stated the facility implemented infection surveillance. The Administrator did not provide any additional information regarding th facility's IPCP. C. On 04/30/25 at 1:27 pm, during an interview, the Interim Director of Nursing (IDON) stated she started her position a few weeks ago. She stated the previous Director of Nursing (DON), who was responsible for the IPCP at the facility, did not give her any documents on the facility's efforts on infection surveillance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. On 04/30/25 at 2:00 pm, during an interview, the Infection Control Preventionist (ICP), stated she started her position 3 weeks ago. She stated the previous DON was responsible for the facility's IPCP but did not give her in any documents regarding the facility's efforts to implement an infection surveillance. She stated she was not aware of what documantation the previous DON should have given her, because she was new to the ICP position. E. On 05/02/25 at 9:44 am, during an interview, the facility's Medical Director (MD) stated he was not aware of his responsibility in implementing and maintaining a proper infection surveillance plan. The MD stated the facility contacted him if they needed to, but the facility did not contact him on a constant basis, like meetings or to coordinate and monitor infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 51919 Based on record review and interview, the facility failed to ensure staff implemented a comprehensive Antibiotic Stewardship Program (ASP, a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use). This failed practice has the potential to affect all 118 residents in the facility. Residents identified on the matrix provided by the Administrator on 04/30/25. This deficient practice could likely result in the inappropriate use of antibiotics and lead to resistance of Multi-Drug Resistant Organisms (MDRO; a germ that is resistant to many antibiotics). The findings are: A. Record review of the facility's Antibiotic Stewardship policy, dated 12/16/24, revealed the purpose of the policy was to reduce inappropriate antibiotic use and prevent the development of antibiotic-resistant organisms. B. Record review of the facility's Infection Prevention and Control Program (IPCP), revealed the facility did not have a proper and adequate ASP that included: 1. Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics. 2. Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools are used for one or more infections. 3. A process for a periodic review of antibiotic use by prescribing practitioners to determine whether an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. 4. Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic. 5. A system for the provision of feedback reports on antibiotic use, antibiotic resistance (the ability of microorganisms, such as bacteria, to withstand the effects of antibiotics that were designed to kill or inhibit their growth) patterns based on laboratory data, and prescribing practices for the prescribing practitioner. C. On 04/30/25 at 1:27 pm during an interview, the facility's Administrator, the Interim Director of Nursing (IDON) and the Infection Preventionist (IP) stated they did not have ongoing monitoring documentation for antibiotic usage patterns or evidence to show an annual review of the Antibiotic Stewardship Program was completed. They stated the previous Director of Nursing (DON) handled the Infection Prevention and Control Program (IPCP) but did not give them any documents to support the facility's efforts toward implementing an ASP. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. On 05/02/25 at 9:44 am, during an interview, the Medical Director (MD) stated he was not aware of his responsibility in implementing and maintaining a proper and adequate ASP. He stated the facility contacted him if they needed to, but the facility did not contact him on a constant basis, like meetings or to coordinate and monitor antibiotics use in the facility. E. On 05/02/25 at 1:30 pm, during an interview, the facility's Consultant Pharmacist (CP) stated he conducted medication regimen reviews (MMRs, a comprehensive assessment of a patient's current and past medications, aimed at identifying and resolving potential drug-related problems) monthly. He stated he expected the facility to implement an ASP, and he could be part of implementing the program.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 35632 51919 Based on observation, record reviews, and interviews, the facility failed to: - Ensure call lights were in working order when staff failed to report and repair two broken call lights on the 400 hall shower room; - Ensure a call light was within reach for 1 (R #120) of 1 (R #120). If the facility is not ensuring a working call light system or maintaining the call light is not within residents' reach, then residents are unable to request immediate assistance when needed. The findings are: A. Record review of the facility's Call Lights Policy, dated 02/01/23, revealed all residents will have a call light or alternative communication device within their reach at all times when unattended. 400 Hall Shower Room B. Record review of a Work Order, dated 04/03/25, revealed staff reported the 400 hall shower room call lights did not have strings. C. Record review of Nurse call system test via TELS, dated 05/01/25, revealed the Maintenance Director inspected 400 hall call lights, including the shower room, on 03/31/25 and 04/28/25. The call lights passed both inspections. D. On 04/29/25 at 3:10 pm, during an observation, two call lights in the 400 hall shower room did not have cords. E. On 04/29/25 at 3:15 pm, during an interview, Certified Nursing Assistant (CNA) #1, CNA #2, and CNA #3 stated they stay with residents while in the shower room. They stated if a resident was independent (could shower alone), then they would give them privacy and instruct them to use the call light when they needed help. All CNAs stated it was not safe to leave those call lights unfixed. The CNAs stated they were aware they should have reported the broken call lights, but they did not. F. On 04/30/25 at 11:14 am, during an interview, Nurse #1 stated nurses and CNAs did not stay with the residents during shower time if a resident was independent. She stated staff instructed residents to use the call light if they needed help during their shower. She stated it was not safe to leave the call lights unfixed. Nurse #1 stated the call lights should have cords, but they did not. Nurse #1 stated she expected CNAs to report the broken call lights when they identified them as broken. (continued on next page)

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	325042	A. Building B. Wing	05/05/2025

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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 04/30/25 at 11:24 am, during an interview, the 400 hall Unit Manager (UM) #1 stated the shower room call light was not functional and needed to be repaired. She stated she expected staff to report the broken call lights to maintenance through The Equipment Lifecycle System (TELS, is a building management platform that helps senior living facilities with maintenance, life safety, and asset management.) She stated all staff have access to TELS. H. On 04/30/25 at 12:40 pm, during an interview, the Interim Director of Nursing (IDON) stated she expected staff to report the broken call lights to maintenance through TELS. She stated staff been trained on using the TELS system. I. On 04/30/25 at 12:45 pm, during an interview, the Administrator stated she expected staff to report the broken call lights to maintenance through TELS. She stated all staff have access to TELS. J. On 05/01/25 at 8:11 am, during an interview, the facility's Maintenance Director stated staff reported the broken call lights in 400 hall shower room. He stated he replaced both call lights. He stated he did monthly random checks on the facility's call lights. He stated he inspected the 400 hall shower room on 04/28/25, as part of his monthly check, and it passed the inspection. The Maintenance Director did not provide documentation to show he repaired the broken call lights when they did not have cords. R #102 K. Record review of R #102's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 04/15/25, indicated R #102 had impairments in both legs. R #102 required substantial assistance from staff with dressing and was dependent on staff for toileting. L, On 04/28/25 at 9:50 am, during an observation and interview, of R #102's call light was on the floor. M. On 04/28/25 at 9:51 am, during an interview, R #102 asked for his call light. He stated he could not reach it and wanted some coffee. N. On 05/02/25 at 12:10 pm, during an observation, of R #102's call light on the floor. R #102 was asleep in his bed. O. On 05/02/25 at 12:18 pm, during an interview, Certified Nursing Assistant (CNA) #8 confirmed R #102's call light was on the floor and not within reach of the resident. CNA #8 stated she was not aware of how long he had been in bed with his call light on the floor. P. On 05/02/25 at 3:27 pm, during an interview with the Unit Manager #1, she stated call lights should be within reach and accessible to the resident. Staff should ensure that call lights are accessible to residents.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for all 118 residents as identified by the facility census provided by the Administrator (ADM) on 04/28/25 when staff failed to: - Ensure oxygen storage room door was not broken. - Ensure the fire door closed when the fire alarm was activated. - Ensure door frames were in good repair - Ensure ceiling tiles were in good repair. - Ensure all electrical outlets were in good repair. These deficient practices are likely to expose residents to an unsafe and uncomfortable environment. The findings are: Oxygen Storage A. Record review of the facility's Compressed Gases policy, revised 03/01/12, revealed the policy did not address the oxygen storage room door. B. On 04/28/25 at 9:26 A.M., observation of the 100 hall revealed the oxygen cylinder closet door was damaged and warped, which allowed it to be pulled open easily. C. On 04/28/25 at 10:32 A.M., during an interview, the Unit Manager (UM #1) stated the door was to remain closed and locked at all times. She stated it was a hazard to have the door unlocked because oxygen was in the closet. Fire Door D. On 04/30/25 at 7:37 A.M., observation revealed the facility conducted a fire drill. Further observation revealed one panel of the smoke doors located on the 300 hall did not close when the fire alarm was activated. The door was held open by a magnetic device, but the device did not release with the activation of the fire alarm. E. On 04/30/25 at 7:45 A.M., during an interview, the Maintenance Director (MD) stated he was aware the door did not release, and he thought it was fixed. He stated it was expected for all doors to close automatically when the fire alarm was activated. Resident #85 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 05/01/25 03:31 P.M., during an observation of R #85's room, one side of the bathroom door frame had rust along the edges, and small flakes of rust fell off the frame when touched. G. On 05/02/25 at 2:30 P.M., during an interview with the MD, he stated he was not aware of the rust on the door frame. He stated a resident could cut themself on the rusted frame and become hurt or sick. 52509 Ceiling Tiles H. Record review of the facility's policies and procedures revealed the facility did not have a policy regarding the maintenance of ceiling tiles. I. On 05/02/25 at 01:25 P.M., observation of the 100 hallway revealed the following: - A ceiling tile located near resident room [ROOM NUMBER] had open space. - A ceiling tile located outside the business office had a 1 inch triangular hole. - A ceiling tile located in the dining room near the exit door had a 1/2 inch hole. - A ceiling tile located in hallway 100, at the entrance doors, had two 1 inch circular holes. J. On 05/02/25 at 12:05 P.M., observation of the Dining Room revealed the following: - A cracked ceiling tile with unsealed space around a sprinkler head. - A cracked ceiling tile with a 1/4 inch unsealed space around the base of a ceiling fan. K. On 05/02/25 at 1:50 P.M., during an interview, the MD stated he was in charge of the life safety and maintenance of the facility. He stated he did not change out the broken ceiling tiles unless staff submitted a work order. He stated he did not have any work orders for ceiling tiles. He stated the holes in the ceiling tiles near the entrance doors of the 100 hall were due to the installation of a cable box for the televisions. He stated he would not expect staff to submit a work order for those ceiling tiles. Electrical receptacles L. Record review of the facility's Electrical Safety and Work Related Practices policy, revised 08/24/24, revealed the following: - Broken or cracked receptacles must be reported and repaired immediately. - The Maintenance Department or service location vendor will inspect all receptacles annually for polarity, ground conductor integrity, contact tension, and overall physical condition. - Defective receptacles shall be replaced. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 05/02/25 at 01:35 P.M., observation revealed the following: - One electrical outlet located in the conference room was broken and detached from the wall. Further observation revealed a water cooler plugged into the outlet. - One electrical outlet located in the resident common area, on the wall next to the television, had a face plate which was cracked and broken. N. On 05/02/25 at 1:50 P.M., during an interview, the MD stated he conducted the resident room outlet inspections in October 2024. He stated he was not aware he had to inspect the outlets that were not located in resident rooms, and he did not have a process for inspecting those outlets. He stated it was expected for staff to submit a work order for the broken outlet and he will fix broken outlets when he sees them. The MD stated the outlet in the conference room should not hang from the wall or be in use in that condition. He stated the outlet in the resident common area should be repaired.