STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325054	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Transitional Rehabilitation Center, LLC	10101 Lagrima DE Oro Road NE Albuquerque, NM 87111

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interviews, the facility failed to safeguard protected health information (PHI) for 4 (R #10, R #11, R #12, and R #13) of 4 (R #10, R #11, R #12, and R #13) residents. If the resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors, and staff. The findings are: A. Record review of the facility's protecting patient/resident privacy policy, provided on 07/01/26, revealed all staff have a responsibility to protect the privacy of patients and residents. The policy states confidential or protected health information on desks or other publicly accessible areas must be secured by using designated work areas or locked storage containers, cabinets, or desks. The policy also states staff must lock the computer screen when stepping away to prevent unauthorized individuals from viewing patient or resident information. B. On 07/01/26 at 1:10 pm, during an observation of the 300 hall, a laptop computer left on an unattended medication cart was open and displaying R #10's electronic health record (EHR). C. On 07/01/26 at 1:15 pm, during an observation of the 300 hall, an unattended medication cart had multiple documents containing residents' PHI exposed on top of the cart, including:A diet order communication form for R #10 containing the resident's room number.A medication list for R #10.An appointment information form for R #11.Appointment information and a physician appointment summary containing physician notes for R #12.An inventory of personal effects form for R #13. D. On 07/07/26 at 1:30 pm, during an interview, the Unit Manager (UM) #1 stated his expectation is for facility computer screens to be locked and patient information not to be left out or visible. UM #1 stated visible patient information is a violation, and all staff are responsible for ensuring patient information is secured. E. On 07/07/26 at 3:34 pm, during an interview, the Corporate Director of Nursing (CDON) stated the facility's expectation is for all resident information to be secured. She stated all staff are responsible for securing resident information, and potential risks include sensitive information being accessible to unauthorized individuals. F. On 07/07/26 at 3:45 pm, during an interview, the Administrator (ADM) stated her expectation is for all resident information to be secured by the person handling the information. The ADM stated if resident information is left visible and unattended, unauthorized individuals may gain access to information they should not have.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325054	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Transitional Rehabilitation Center, LLC	10101 Lagrima DE Oro Road NE Albuquerque, NM 87111

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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 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. Based on observation, record review, and interviews, the facility failed to ensure staff properly stored and secured medications for all residents on the 300 hall when the hall medication cart (a mobile storage unit equipped with drawers and locking mechanisms to hold medications) was not secured and was left unattended. If the facility fails to secure medication carts, residents are likely to experience unauthorized access to medications, potentially resulting in injury or illness.The findings are: A. Record review of the facility's medication storage policy, revised January 2026, revealed the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy states medication rooms, cabinets, and medication supplies must remain locked when not in use or when not attended by authorized personnel. B. On 07/01/26 at 1:15 pm, during an observation of the 300 Hall, an unlocked medication cart was positioned in the hallway without staff present, and the cart remained unattended and accessible to anyone walking through the area. C. On 07/01/26 at 1:25 pm, during an interview, Registered Nurse (RN) #1 stated he left the medication cart unlocked. RN #1 stated the cart contained narcotic (opioid) medications stored inside a locked box, and the remaining drawers contained other resident medications. RN #1 stated if the medication cart is left unlocked, a resident could take and misuse medications not prescribed to them. D. On 07/01/26 at 1:30 pm, during an interview, the Unit Manager (UM) #1 stated his expectation is for all medication carts to be locked and secured. UM #1 stated all clinical staff are responsible for ensuring medication carts remain locked and secured. UM #1 stated if medication carts are left unlocked, residents are at risk of taking medications not prescribed to them and becoming ill. E. On 07/01/26 at 3:34 pm, during an interview, the Corporate Director of Nursing (CDON) stated the facility's expectation is for all medication carts to remain locked, and the nurse assigned to the cart is responsible for ensuring it is secured. She stated residents are at risk of taking medication that is not theirs if the medication carts are left unlocked and unattended.