

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Canyon Transitional Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196</p> <p>Based on record review and interview the facility failed to ensure advance directives (a document which provides an individual's wishes for emergency and life saving care) were complete for 1 (R #45) of 1 (R #45) resident reviewed for advance directives when staff failed to ensure the resident signed the advance directive. This deficient practice is likely to result in residents receiving unwanted or unplanned treatment during a medical emergency. The findings are:</p> <p>A. Record review of R #45 electronic medical record (EMR) revealed R #45 elected a code status of do not resuscitate [DNR; a medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient's heart stops beating or breathing stops.]</p> <p>B. Record review of R #45's Medical Orders for Scope of Treatment (MOST; an advance directive) form, dated [DATE], revealed the resident did not sign it.</p> <p>C. On [DATE] at 3:48 PM during an interview, the Director of Nursing (DON) stated R #45's MOST form should be signed by the resident, but it was not.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>35632</p> <p>Based on observation, interview and record review, the facility failed to notify the physician or the nurse practitioner for 2 (R #29 and #132) of 2 (R #29 and #132) residents for:</p> <ol style="list-style-type: none"> 1. R #29 who had significant amount of pain. 2. R #132 who did not receive several doses of his intravenous (IV; a tube inserted into a blood vessel and used to administer medications, fluids, or nutrition into the bloodstream) antibiotic. <p>If the facility is not notifying the physician or nurse practitioner of changes in a residents medical condition then the resident will not receive prompt medical care and could cause a delay in treatment, unnecessary pain, and could create more serious health complications. The findings are:</p> <p>Resident #29</p> <p>A. On 11/25/24 at 11:14 am, during an observation and interview of R #29, she rubbed her hand and cried. R #29 stated she was in a lot of pain. She stated staff gave her Tylenol (pain medication) a little bit ago, but it did not help. She stated her pain level was an 11 (the pain scale indicates pain based on 1 being the lowest and 10 being highest.)</p> <p>B. Record review of R #29's medical record indicated staff documented the resident's pain level was a 10 on 11/25/24 at 10:52 am, and staff administered Tylenol.</p> <p>C. Record review of R #29's medication administration note revealed that staff gave R #29 two Tylenol 500 mg on 11/25/24 at 10:50 am and at 12:18 pm, and staff noted the medication was ineffective. Staff did not document anything else in the progress notes after the medication was found to be ineffective.</p> <p>D. On 11/25/24 at 11:45 am, during an interview with Nurse #1, she stated she was aware R #29 asked for another medication for her pain, but R #29 did not have an order for another pain medication. She stated R #29 only had an order for Tylenol for pain, and she gave the resident some Tylenol a little bit ago. She stated R #29 was not due to receive another dose of Tylenol at this time. She stated R #29 did not have an order for an as needed (PRN) pain medication. Nurse #1 stated she did not notify the provider.</p> <p>E. Record review on 11/26/24 of R #29's medical record physician progress notes, nursing progress notes, and physician orders revealed staff did not notify the physician or nurse practitioner of R #29's pain level.</p> <p>F. On 12/02/24 at 2:32 pm, during an interview with the Unit Manager, he stated he expected staff to document a progress note regarding notification of the physician of R #29's pain. He stated staff should have documented a change in condition (CIC; when there is a change from what is a person's normal baseline) due to pain of an 11 and notified the physician. He stated if the nurse found the Tylenol was not effective then the nurse should have notified the physician.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>51919</p> <p>Resident #132</p> <p>F. Record review of R #132's provider's orders, dated 11/12/24, revealed an order to administer vancomycin (an antibiotic medication) IV solution, 750 milligrams (mg)/150 milliliter (ml) for discitis/osteomyelitis (a serious condition that causes inflammation of the discs in the spine) every eight hours.</p> <p>G. Record review of R #132's medication administration record (MAR), dated November 2024, revealed staff did not administer R #132 the vancomycin on 11/25/24 at 6:00 am, 2:00 pm, and 10:00 pm due to medication was not received.</p> <p>H. On 11/25/24 at 9:53 am and 11/25/24 at 2:31 pm, during an interview with Nurse #1, she stated vancomycin was not available to administer to R #132, because the pharmacy did not deliver it. Nurse #1 stated she called the pharmacy on 11/24/24 and the morning of 11/25/24 to request a vancomycin delivery.</p> <p>I. On 11/27/24 9:16 am and 9:25 am, during an interview with the Nurse Practitioner (NP), he stated he was not aware R #132 missed doses of the vancomycin, because the nursing staff did not notify him. He stated he became aware when he saw the on-call provider's report in his email on the morning of 11/27/24. The NP stated he was on the floor during the time when R #132 missed his vancomycin doses, and a communication book was available by his office door. He stated the communication book did not contain any mention of the situation. He stated he expected nurses and other healthcare staff at the facility to notify him of any missed medications doses for R #132. He added he would contact the Infectious Disease Team (a medical clinic that R #132 follows up with regarding his infection) if staff made him aware. He stated if the staff had notified him, then he would also call the pharmacy to order a vancomycin trough blood level test (a test that measures the concentration of vancomycin in the blood) in order to see if the pharmacy staff needed to make an adjustment on the vancomycin's course of treatment.</p> <p>J. On 11/27/24 at 9:38 am during an interview with Nurse #2, she stated she was expected to notify the floor NP regarding any missed medications doses for R #132.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>50752</p> <p>Based on interviews and observations, the facility failed to provide a clean, homelike environment for all 21 residents who lived on the 400 hall. This deficient practice is likely to result in residents not feeling comfortable, which could affect their psychological well-being.</p> <p>The findings are:</p> <p>A. On 11/25/24 at 8:00 a.m., observation during the initial tour of the building revealed the 400 hall had a strong odor of urine and feces throughout.</p> <p>B. On 11/27/24 at 11:06 a.m., during an interview, R #266 stated she had a bedside commode. She stated she did not always put the lid down, because she frequently needed to use the bathroom. She stated she missed the bedside commode in the past while she tried to open the lid.</p> <p>C. On 11/23/24 at 11:06 a.m., it was observed that R#266 bedside commode sat next to the resident's bed, the lid was up, and urine was in the commode.</p> <p>D. On 11/27/24 at 11:15 a.m., during an interview with Certified Nursing Assistant (CNA) #1, she stated R #266 did not keep the lid on her bedside commode down after she used it, which made the 400-hallway smell of urine.</p> <p>E. On 11/27/24 at 2:00 p.m., during an interview, R #20 stated he could smell the odors in the hallway, and it bothered him.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on interview and record review, the facility failed to ensure staff completed the comprehensive care plans for 2 (R #23 and R #166) of 2 (R #23 and R #166) residents reviewed for care plans, when staff failed to:</p> <p>1. Complete care plans for R #23 for the following areas: Activities of daily living (ADL; basic self-care tasks) care, psychotropic medications (medications that affect behavior, mood, thoughts and perception), and respiratory complications; and 2. Complete care plans for R #166 for the following areas: ADL care, cardiovascular (heart) symptoms or complications, oral health, diabetes (high blood sugar levels), anemia (not having enough healthy red blood cells), and anticoagulant (medication that thins the blood) medication use.</p> <p>This failure has the potential to adversely affect staff's ability to implement preventative measures for the residents' health and well-being. The findings are:</p> <p>Resident #23</p> <p>A. Record review of face sheet for R #23 revealed an admitted [DATE] and included the following diagnoses:</p> <ul style="list-style-type: none"> - Muscle weakness; - Lack of coordination; - Unsteadiness on feet; - Reduced mobility; - Conduct disorder (a behavioral and emotional disorder that presents as repetitive, disruptive and violent behavior); - Fatigue (a feeling of tiredness or lack of energy); - Mental disorders due to known physiological condition (a broad group of severe mental and behavioral disorders); - Respiratory failure with hypoxia (when you don't have enough oxygen in your blood); and - Need for assistance with personal care. <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Record review of Physicians Orders for R #23 revealed the following:- Sertraline (medication used to treat anxiety) oral tablet, 25 milligrams (mg). Give one tablet by mouth in the morning for anxiety. Start date: 11/14/24. End date: 11/22/24.- Sertraline oral tablet 50 mg. Start date: 11/23/24.- Trazodone (medication used to treat depression) oral tablet, 50 mg. Start date: 11/21/24.- Buspirone (medication used to treat anxiety). Start date 11/13/24.- Olanzapine (medication used to treat mental disorders and depression) oral tablet, 2.5 mg.</p> <p>C. Record review of Care Plan dated 10/15/23 for R #23 revealed that R #23 required assistance with ADL care. Staff did not complete any additional information to include ADSs, goals and interventions.</p> <p>- Dated 09/23/24, Focus: Resident was at risk for complications related to the use of psychotropic drugs. Staff did not complete the Goal Section.</p> <p>- Dated 10/15/24, Focus: Resident exhibited or was at risk for respiratory complications related to recent hospitalization . Staff did not complete the Goal Section to include the number of days the resident would not have signs or symptoms of respiratory distress.</p> <p>Resident #166</p> <p>D. Record review of face sheet for R #166 revealed an admitted [DATE] and included the following diagnoses:</p> <p>- Type 2 diabetes mellitus with the following complications: 1) diabetic retinopathy (eye disease caused by diabetes) with macular edema (swelling in the eye), 2) diabetic nephropathy (kidney disease caused by diabetes), and 3) hyperglycemia (high blood sugar);</p> <p>- Cerebrovascular disease (conditions that affect blood flow to the brain);</p> <p>- Hyperlipidemia (high levels of fat in the blood);</p> <p>- Hypertension (high blood pressure);</p> <p>- History of venous thrombosis (formation of blood clots in the veins) and embolism (blood clot that blocks the flow of blood).</p> <p>E. Record review of the care plan for R #166 revealed the following:</p> <p>- Dated 11/25/24, R #166 required assistance with ADL care. Staff did not complete any additional information to include ADLs, goals, and interventions.</p> <p>- Dated 11/25/24, Focus: Resident exhibited or was at risk for cardiovascular symptoms or complications related to diagnosis of hypertension, hyperlipidemia, and history of stroke. Staff did not complete the Goal Section to include the number of times a day the resident would participate in skilled physical therapy/occupational therapy without any signs or symptoms of activity intolerance.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Dated 11/25/24, Focus: The resident had a diagnosis of diabetes and was insulin dependent. Staff did not complete the Goal Section to include the number of days the resident would not have signs or symptoms of hypo/hyperglycemia (low/high blood sugar).</p> <p>- Dated 11/25/24, Focus: Resident was at risk for injury or complications related to the use of anticoagulation therapy medication, Apixaban (brand name.) Staff did not complete the Goal Section to include the number of days the resident would not have signs or symptoms of bleeding.</p> <p>E. On 12/02/24 at 1:43 pm during an interview, the Director of Nursing (DON) stated the care plans were incomplete for R #23 and #166, and staff should have completed the care plans.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on record review and interview, the facility failed to provide care that met professional standards for 1 (R #60) of 3 (R #23, #60 and #16) residents when the facility failed to maintain and care for R #60's gastrostomy tube (g-tube; a tube surgically inserted through the abdomen into the stomach and used to provide fluids, nourishment and medications.) This deficient practice is likely to result in residents not receiving proper nutritional needs and also places residents at risk for complications and infections that may affect their quality of life. The findings are:</p> <p>A. Record review of the facility's policy, Enteral Management, dated 03/01/22, revealed staff to provide safe and effective management of enteral tubes.</p> <p>B. Record review of the facility's policy, Enteral Tubes Medication Administration, dated 03/01/22, revealed guidelines for managing complications. Staff directed to do the following:</p> <ol style="list-style-type: none"> 1. Check first to see the tube was not kinked. 2. If the feeding tube became clogged, then interventions should occur immediately. Warm water should be tried first. 3. Clogged tube - Clogging can occur from internal blockage. <ol style="list-style-type: none"> a. If the clog was still present, then gently milk the tube from top to bottom to release any clog that may be in that part of the tube. b. Do not force-flush the tube or use a rigid object in an attempt to clear the tube. If the clog was persistent, then contact the medical doctor (MD) if the above techniques fail. <p>Resident #60</p> <p>C. Record review of the face sheet for R #60, dated 11/23/24, revealed an initial admitted [DATE] and included the following diagnoses:</p> <ul style="list-style-type: none"> - Severe protein-calorie malnutrition, - Aphasia (disorder that impairs the ability to process language), - Dysphasia (difficulty swallowing), - Dysarthria (when the muscles used for speech are weak or hard to control) and anarthria (severe form of dysarthria), - Aphasia (language disorder that affects the ability to speak and understand what others say), - Gastrostomy status (surgical procedure for inserting a tube through the abdomen into the stomach for administration of food, fluids and medications), <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Ileus (condition where your intestines can't push food and waste out of the body).</p> <p>D. Record review of physician's orders for R #60, various dates, revealed orders for staff to administer R #60's medications via g-tube.</p> <p>E. Record review of Change in Condition for R #60, dated 11/10/24 at 9:14 pm, revealed the resident's percutaneous endoscopic gastrostomy (PEG; a type of g-tube) was clogged. Staff unable to unclog the PEG and notified the on-call provider. Provider ordered medication to aid unclogging PEG. Will attempt as soon as the medication becomes available.</p> <p>F. Record review of the physician's progress notes, dated 11/10/24 at 11:00 pm, revealed the resident's PEG was clogged. Previously had medication ordered to unclog PEG tube, but it was unavailable from pharmacy. Order given to go ahead with Creon (medication that contains a combination of enzymes that help digest fats, proteins, and sugars) medication to assist with unclogging PEG tube.</p> <p>G. Record review of progress notes for R #60 revealed the following:</p> <p>- Dated 11/11/24 at 12:45 pm, Nurse Management note: Review of change in condition, dated 11/10/24. Clogged g-tube noted. Attempted multiple ways to unclog g-tube, to include declogger soda and pressure unsuccessfully. Resident sent to emergency room for possible new tube.</p> <p>- Dated 11/11/24 at 3:35 pm, Patient was transferred to hospital 2:23 pm on this day due to his g-tube became clogged. This nurse, as well as other nurses, tried to unclog the g-tube. Using pressure, carbonated beverages, warm water, and wand to unclog tube.</p> <p>H. Record review of hospital discharge documentation for R #60, dated 11/11/24, revealed the resident had a past medical history of stroke, status post (after) g-tube placement, and was brought in by emergency medical services (EMS) from the nursing facility for an evaluation of a g-tube issue. Patient's g-tube got clogged last night. Today the nursing facility staff attempted to unclog this with five cleaners and Dr. Pepper; however, they were unsuccessful. Patient did not report abdominal pain and did not have any complaints today. He acknowledged there was a clog in his g-tube. On chart review, patient had a gastrostomy tube placed on 10/22/2024. Initial vital signs revealed tachycardia, and that resolved without intervention. Physical exam revealed a soft, non-tender abdomen. Attempted to flush the catheter without success. Then placed an endotracheal stylette (small, unbreakable, plastic coated metal rod) also without success. Contacted interventional radiology (offers patients an image guided minimally invasive procedure to alleviate a condition that could be otherwise be potentially life-threatening) for assistance. They used a [NAME] syringe (a disposable syringe used for irrigating wounds and catheters) with pressure and dislodged the clot. Patient was stable for discharge back to his facility. Recommend he follow-up with his primary care provider and return to the hospital with any concerns.</p> <p>I. On 12/02/24 1:48 pm during an interview, the Director of Nursing (DON) stated the staff used declogger wands to unclog the resident's PEG, and the Nurse Practitioner (NP) #1 advised them to use the soda method. The DON stated using soda or carbonated beverages to unclog a g-tube was probably not considered best practice.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>35632</p> <p>Based on observation, record review, and interview the facility failed to provide adequate and timely pain relief for 1 (R #29) of 2 (R #29 and #132) residents reviewed for pain. This deficient practice likely resulted in R #29 to be in significant pain. The findings are:</p> <p>Resident #29</p> <p>A. On 11/25/24 at 11:14 am, during an observation and interview of R #29, she rubbed her hand and cried. R #29 stated she was in a lot of pain. She stated staff gave her Tylenol a little bit ago, but it did not help. She asked the Certified Nursing Assistant (CNA) #6 to ask the nurse to bring her the medication for her nerve pain, and the CNA stated he would tell the nurse. R #29 stated that sometimes the Tylenol worked and sometimes it did not. She stated her pain level was an 11.</p> <p>B. Record review of the physicians orders for R #29 indicated an order for Tylenol extra strength, oral tablet 500 milligrams (mg). Give two tablets by mouth every eight hours as needed for generalized pain.</p> <p>C. Record review of the medical record for R #29 indicated staff documented the resident's pain level to be a 10 (the pain scale indicates pain based on 1 being the lowest and 10 being highest) on 11/25/24 at 10:52 am.</p> <p>D. Record review of the Medication Administration Record (MAR) for R #29 revealed the following:</p> <ul style="list-style-type: none"> - Dated 11/25/24 at 10:50 am, staff administered two Tylenol 500 mg to R #29 for pain. - Dated 11/25/24 at 12:18 pm, staff noted the Tylenol was ineffective for the resident's pain. - Staff did not document anything else after the medication was determined to be ineffective. <p>E On 11/25/24 at 11:35 am, during an interview with CNA #6, he stated he informed the nurse of R #29's pain and requested her pain medication.</p> <p>F. On 11/25/24 at 11:45 am, during an interview with Nurse #1, she stated she was aware R #29 asked for another medication for her pain, but R #29 did not have another pain medication on order. She stated R #29 only had Tylenol for pain, and she gave the resident some Tylenol a little bit ago. She stated R #29 was not due to receive another dose of Tylenol at this time. She stated R #29 did not have anything else ordered for pain, like another as needed (PRN) pain medication. She stated R #29 did not have an order for an as needed (PRN) pain medication. Nurse #1 stated she did not notify the provider.</p> <p>G. On 12/02/24 at 2:32 pm, during an interview with the Unit Manager, he stated he expected staff to document a progress note regarding notification of the physician of R #29's pain. He stated staff should have documented a change in condition (CIC; a change in what is baseline or normal for a person) due to pain of an 11 and notified the physician. He stated if the nurse found the Tylenol was not effective then the nurse should have notified the physician.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>51919</p> <p>Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not exceed 5 percent (%) for 7 residents (R #25, #32, #52, #130, #131, #132, and #317) of 11 residents (R #3, #16, #25, #31, #32, #45, #52, #130, #131, #132, and #317) reviewed during medication administration. Staff administered 80 medications with 39 errors, which resulted in a medication error rate of 48.75 %. If medications are administered in error, residents are likely to experience less than optimal results from their medication regimen. The findings are:</p> <p>R #25</p> <p>A. Record review of R #25's physician orders, dated 12/2/24, revealed the following:</p> <ul style="list-style-type: none"> - Potassium oral tablet (treats hypokalemia; a condition where the level of potassium in blood is lower than normal), 20 milliequivalents (meq). Give one tablet by mouth for hypokalemia at 8:00 am. - Sotalol oral tablet (manages blood pressure), 80 milligrams (mg). Give one tablet by mouth for high blood pressure at 8:00 am. - Sertraline oral tablet (treats depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), 50 mg. Give one tablet by mouth for depression at 8:00 am. - Furosemide oral tablet (treats congestive heart failure; impaired heart function), 40 mg. Give one tablet by mouth for congestive heart failure at 8:00 am. - Flovent inhaler (treats shortness of breath). One puff inhaled orally for shortness of breath at 8:00 am. - Lidocaine patch (relieves nerve pain). Apply one patch to right hip topically for pain at 8:00 am. <p>B. On 11/25/24 at 09:15 am during observation of Nurse #1, she administered the following morning medications to R #25:</p> <ul style="list-style-type: none"> - Potassium oral tablet, 20 meq. - Sotalol oral tablet, 80 mg. - Sertraline oral tablet, 50 mg. - Furosemide oral tablet, 40 mg. - Flovent inhaler, one puff. - Lidocaine patch. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. On 11/25/24 at 9:15 am during an interview with Nurse #1, she stated she passed the morning medications for the 100 hall late, because the Certified Medication Aide (CMA) assigned to the hall did not come to work.</p> <p>D. On 11/25/24 at 9:15 am during observation, Nurse #1 attempted to administer medication to R #23, but the resident asked if she could postpone her medications. Nurse #1 took R #23's medications and put them in the medication cart. Nurse #1 then went to ask the Nurse Manager to talk to the resident. The resident decided to take her medications without delaying them. Nurse #1 did not inform R #25 about the medications being administered.</p> <p>R #32</p> <p>E. Record review of R #32's physician orders, dated 12/2/24, revealed the following:</p> <ul style="list-style-type: none"> - Lidocaine patch (relieves nerve pain). Apply one patch to affected area topically for pain at 8:00 am. -Apixaban oral tablet (treats vascular accident (CVA; a condition when an area of the brain becomes damaged from lack of blood supply to the brain) 5 mg. Give one tablet by mouth for CVA at 8:00 am. -Benzonatate oral capsule (treats cough), 100 mg. Give one capsule by mouth for cough at 8:00 am. -Guaifenesin oral tablet (treats cough), 600 mg. Give one tablet by mouth for cough at 8:00 am. -Sulfasalazine oral tablet (treats rheumatoid arthritis; a chronic disease where body's immune system mistakenly attacks the lining of joints), 500 mg. Give one tablet by mouth for rheumatoid arthritis at 8:00 am. -Furosemide oral tablet, 40 mg. Give one tablet by mouth as a diuretic at 8:00 am. -Nebulization treatment solution (treats cough and shortness of breath), 3 milliliter (ml) inhale orally via nebulizer for cough and shortness of breath at 8:00 am. <p>F. On 11/25/24 at 9:27 am during observation of Nurse #1, she administered the following morning medications to R #32:</p> <ul style="list-style-type: none"> - Lidocaine patch. -Apixaban oral tablet, 5 mg. -Benzonatate oral capsule, 100 mg. -Guaifenesin oral tablet, 600 mg. -Sulfasalazine oral tablet, 500 mg. -Furosemide oral tablet, 40 mg. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Nebulization treatment solution.</p> <p>G. On 11/25/24 at 9:27 am during observation of Nurse #1, she did not inform R #32 about the medications being administered.</p> <p>R #317</p> <p>H. Record review of R #317's physician orders, dated 12/2/24, revealed the following:</p> <p>-Losartan oral tablet (manages high blood pressure), 50 mg. Give one tablet by mouth for high blood pressure at 8:00 am.</p> <p>-Carvedilol oral tablet (manages high blood pressure), 12.5 mg. Give one tablet by mouth for high blood pressure at 8:00 am.</p> <p>-Ticagrelor oral tablet (prevents blood clots), 90 mg. Give one tablet by mouth to prevent blood clots at 8:00 am.</p> <p>I. On 11/25/24 at 9:32 am during observation of Nurse #1, she administered the following morning medications to R #317:</p> <p>-Losartan oral tablet, 50 mg.</p> <p>-Carvedilol oral tablet, 12.5 mg.</p> <p>-Ticagrelor oral tablet, 90 mg.</p> <p>R #130</p> <p>J. Record review of R #130's physician orders, dated 12/2/24, revealed the following:</p> <p>-Venlafaxine oral tablet (treats depression), 75 mg. Give one tablet by mouth for depression at 8:00 am.</p> <p>-Baclofen oral tablet (relieves muscle spasms), 10 mg. Give one tablet by mouth for muscle spasm at 8:00 am.</p> <p>K. On 11/25/24 at 9:40 am during observation of Nurse #1, she administered the following morning medications to R #130:</p> <p>-Venlafaxine oral tablet, 75 mg.</p> <p>-Baclofen oral tablet, 10 mg.</p> <p>R #131</p> <p>L. Record review of R #131's physician orders, dated 12/2/24, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Protonix oral tablet (treats gastroesophageal reflux disease (GERD; a condition in which the stomach contents move up into the esophagus), 40 mg. Give one tablet by mouth for GERD at 8:00 am.</p> <p>-Wellbutrin oral tablet (treats depression), 150 mg. Give one tablet by mouth for depression at 8:00 am.</p> <p>M. On 11/25/24 at 9:40 am during observation of Nurse #1, she administered the following morning medications to R #131:</p> <p>-Protonix oral tablet, 40 mg.</p> <p>-Wellbutrin oral tablet, 150 mg.</p> <p>R #132</p> <p>N. Record review of R #132's physician orders, dated 12/2/24, revealed the following:</p> <p>-Oxcarbazepine oral (treats seizures; a disorder in which nerve cell activity in the brain is disturbed, causing seizures), 300 mg. Give one tablet for seizures at 8:00 am.</p> <p>-Tylenol oral tablet (relieves pain), 325 mg. Give two tablets for pain at 8:00 am.</p> <p>-Gabapentin oral capsule (relieves pain), 300 mg. Give one capsule for pain at 7:00 am.</p> <p>-Paroxetine oral tablet (treats mood disorder; a mental health condition that affects a person's emotional state, causing long periods of extreme sadness, happiness, or both), 40 mg. Give one tablet for mood disorder at 8:00 am.</p> <p>-Amantadine oral tablet (treats intellectual disability; a chronic condition that limits a person's ability to learn, think, and perform daily activities) and traumatic brain injury (TBI; a brain injury caused by an outside force, such as a blow or jolt to the head, or an object piercing the skull), 100 mg. Give one tablet for intellectual disability and TBI at 8:00 am.</p> <p>-Metoprolol oral tablet (manages high blood pressure), 25 mg. Give one tablet for high blood pressure at 8:00 am.</p> <p>- Vancomycin intravenous (IV; into a vein), (treats discitis/osteomyelitis; infection of the spine), 750 mg/150 ml. Infuse 150 ml intravenously for discitis/osteomyelitis at 6:00 am.</p> <p>O. On 11/25/24 at 9:53 am during observation of Nurse #1, she administered the following morning medications to R #132:</p> <p>-Oxcarbazepine oral tablet, 300 mg.</p> <p>-Tylenol oral tablet, 650 mg.</p> <p>-Gabapentin oral capsule, 300 mg.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Paroxetine oral tablet, 40 mg.</p> <p>-Amantadine oral tablet, 100 mg.</p> <p>-Metoprolol oral tablet, 25 mg.</p> <p>-Vancomycin intravenous, 750 mg/150 ml.</p> <p>P. On 11/25/24 at 9:53 am, during an interview with Nurse #1, she stated she contacted the pharmacy to deliver vancomycin on 11/24/24 and again on 11/25/24. She stated the vancomycin was not delivered yet. She stated R #132 missed his 6:00 am dose of vancomycin. Nurse #1 stated we will be lucky if we receive it by the end of this week.</p> <p>R #52</p> <p>Q. Record review of R #52's physician orders, dated 12/2/24, revealed the following:</p> <p>-Amoxicillin-pot clavulanate oral tablet (treats gangrene on medial right ankle; means that the inner side of the right ankle is affected by gangrene; a serious condition that occurs when body tissue dies), 875-125 mg. Give one tablet by mouth for gangrene on medial right ankle at 8:00 am.</p> <p>-Cilostazol oral tablet (treats symptoms of intermittent claudication; is a muscle pain during activity that stops when the person rests), 100 mg. Give one tablet by mouth for symptoms of intermittent claudication at 8:00 am.</p> <p>-Escitalopram oral tablet (treats depression), 20 mg. Give one tablet by mouth for depression at 8:00 am.</p> <p>-Gabapentin oral capsule (relieves pain), 300 mg. Give three capsules by mouth for pain at 8:00 am.</p> <p>-Isosorbide oral tablet (treats coronary artery disease; a heart disease that occurs when the arteries supplying blood to the heart narrow due to plaque buildup), 30 mg. Give one tablet by mouth for coronary artery disease at 8:00 am.</p> <p>-Losartan oral tablet (manages high blood pressure), 50 mg. Give one tablet by mouth for high blood pressure at 8:00 am.</p> <p>-Metoprolol oral tablet (manages high blood pressure), 100 mg. Give one tablet by mouth for high blood pressure at 8:00 am.</p> <p>-Tapazole oral tablet (treats hyperparathyroidism; a disorder in which 1 or more of the parathyroid glands in the neck produce too much parathyroid hormone)</p> <p>, 10 mg. Give one tablet by mouth for hyperparathyroidism at 8:00 am.</p> <p>R. On 11/26/24 at 8:10 am during observation of Certified medication Aid (CMA) #1, she administered the following morning medications to R #52:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Amoxicillin-pot clavulanate oral tablet, 875-125 mg.</p> <p>-Cilostazol oral tablet, 100 mg.</p> <p>-Escitalopram oral tablet, 20 mg.</p> <p>-Gabapentin oral capsule, 900 mg.</p> <p>-Isosorbide oral tablet, 30 mg.</p> <p>-Losartan oral tablet, 50 mg.</p> <p>-Metoprolol oral tablet, 100 mg.</p> <p>-Tapazole oral tablet, 10 mg.</p> <p>S. On 11/26/24 at 8:10 am during observation of CMA #1, she did not inform R #52 about the medications being administered. CMA #1 stated she would inform R #52 about her medications if she asked.</p> <p>T. On 12/02/24 at 2:52 pm during interview with Nurse #4, she stated staff should administer resident medications within a two hour period, one hour before to one hour after the time stated on the resident's orders.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51919</p> <p>Based on record review, observation, and interview, the facility failed to keep a resident free from significant medication errors for 1 (R #132) of 1 (R #132) residents when they failed to administer R #132's vancomycin (an antibiotic medication) intravenous (IV; a tube that is inserted into a blood vessel and used to administer medications, fluids, or nutrition into the bloodstream) medication in a timely manner as per the physician's order. This deficient practice is likely to cause R #132 to have adverse drug effects including but not limited to lowering the effectiveness of the antibiotic treatment and potentially contributes to antimicrobial resistance (when microorganisms, like bacteria, viruses, fungi, and parasites, change and are no longer affected by the drugs used to treat them).</p> <p>The findings are:</p> <p>A. Record review of R #132's face sheet, dated 11/12/24, revealed he was admitted to the facility on [DATE] with multiple diagnoses including but not limited to:</p> <ul style="list-style-type: none"> - Osteomyelitis of vertebra, lumber region (a rare bone infection of the spine that can occur when bacteria or fungi spread to the bones.) - Discitis, unspecified, lumber region (a serious condition that causes inflammation of the discs in the spine.) - Bacteremia (the presence of bacteria in the blood.) <p>B. Record review of R #132's provider's orders revealed the following:</p> <ul style="list-style-type: none"> - Dated 11/12/24, administer vancomycin intravenous solution, 750 milligrams (mg)/150 milliliter (ml) for discitis/osteomyelitis every eight hours. - Dated 11/13/24, use 10 ml of normal saline (a solution of water and salt that's 0.9% sodium chloride commonly used in the clinical setting) flush solution to flush the PICC line intravenously every shift prior to medication administration. <p>C. On 11/25/24 at 9:53 am, during observation of Nurse #1 administering medications to R #132, the resident had a peripherally inserted central catheter (PICC; a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein near the heart, is used for long-term IV antibiotics, nutrition or medications, and for blood draws) in the right upper arm.</p> <p>D. On 11/25/24 at 9:53 am and 2:31 pm, during an interview with Nurse #1, she stated the vancomycin was not available to administer to R #132 since the pharmacy did not deliver it. Nurse #1 stated she called the pharmacy on 11/24/24 and the morning of 11/25/24 to request a vancomycin delivery.</p> <p>E. Record review of R132's Medication Administration Record (MAR), dated November 2024, revealed R #132 missed vancomycin doses as follows:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 11/25/24 at 6:00 am, 2:00 pm, and 10:00 pm due to medication was not received from the pharmacy.</p> <p>- On 11/26/24 at 2:00 pm and 10:00 pm due to PICC line was clogged and not usable for medications or fluids administration.</p> <p>- On 11/27/24: 6:00 am due to PICC line was clogged and not usable for medications or fluids administration.</p> <p>F. On 11/26/2024 at 8:30 am, during an interview with Nurse #2, she stated R #132's PICC line was clogged, and she was not able to administer the vancomycin dose on time. She stated a specialized nurse from an outside agency attempted to unclog R #132's PICC line but did not succeed.</p> <p>G. Record review of R #132's progress notes ,dated 11/27/24, revealed the specialized nurse attempted to unclog the PICC line at 2:33 am with no success. He then advised that another specialized nurse needed to insert a new PICC line in the morning of 11/27/24.</p> <p>H. On 11/27/2024 at 8:55 am, during an interview with the Director of Nursing (DON), she stated she was not aware of R #132's PICC line situation. She stated the Nurse Manager would handle similar situations. She stated if staff had notified her of the incident, then she would have called the pharmacy and the specialized team who were supposed to come over and unclog the PICC line. She also stated the medication room might have vancomycin in stock, and the facility nurses were expected to check if vancomycin was available in the medication room stock</p> <p>I. On 11/27/24 at 9:03 am, during an interview with Nurse #2, she stated that vancomycin, 750 mg, was not available in stock. She stated she called the pharmacy three times on three different occasions on 11/26/24. She stated she inquired regarding when the pharmacy would send the alteplase (a medication that dissolves blood clots, and was ordered to be used in an attempt to unclog the PICC line by a specialized nurse from outside the facility.) She added the alteplase arrived on 11/26/24 around 4:00 pm, and she called the specialized nurse to come and attempt to unclog the PICC line. She stated that attempt was unsuccessful.</p> <p>J. On 11/27/24 9:16 am and 9:25 am, during an interview with the Nurse Practitioner (NP), he stated he was not aware R #132 missed doses of the vancomycin, because the nursing staff did not notify him. He stated he became aware when he saw the on-call provider's report in his email on the morning of 11/27/24. The NP stated he was on the floor during the time when R #132 missed his vancomycin doses, and a communication book was available by his office door. He stated the communication book did not contain any mention of the situation. The NP stated he reviewed the on-call report (a medical report where the on-call providers write their notes and send them to the NP on daily basis) dated 11/26/24 and he found out the floor nurse called the on-call provider to report the clogged PICC line. He stated he expected nurses and other healthcare staff at the facility to notify him of any missed medications doses for R #132. He added he would contact the Infectious Disease Team (a medical clinic that R #132 follows up with regarding his infection) if staff made him aware. He stated if the staff had notified him, then he would also call the pharmacy to order a vancomycin trough blood level test (a test that measures the concentration of vancomycin in the blood) in order to see if the pharmacy staff needed to make an adjustment on the vancomycin's course of treatment.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51919</p> <p>Based on observations, interviews and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure medication refrigerators did not contain medications that belonged to discharged residents. 2. Ensure nurses and CMAs dated opened insulin (a medication prescribed to help the body turn food into energy and manages blood sugar levels) vials and discarded them within 28 days of opening. 3. Ensure medication carts did not contain medications that belonged to discharged residents. <p>These deficient practices are likely to result in residents receiving medications that are less effective or expired for all 70 residents who reside in the facility, as identified on the census list provided by the facility Administrator on [DATE].</p> <p>The findings for the medication refrigerator:</p> <p>A. On [DATE] at 10:50 am, during observation of medication refrigerator located inside the medication room, revealed the following:</p> <ol style="list-style-type: none"> 1. Lispro 10 milliliter multiple-dose vial insulin (a short-acting insulin) vial was open and did not have an opening date. The insulin vial belonged to R #8. 2. Vancomycin (an antibiotic medication) syrup bottle was open and did not have an opening date. The medication belonged to R #316. <p>B. Record review of the manufacturer's instructions for Lispro multiple dose vial insulin revealed staff to throw away all opened vials after 28 days of use, even if there is insulin left in the vial.</p> <p>C. Record review of R #8's physician orders, dated [DATE], revealed R #8 was actively receiving lispro insulin.</p> <p>D. Record review of R #316's face sheet, dated [DATE], revealed R #316 was discharged from the facility on [DATE].</p> <p>E. On [DATE] at 10:55 am, during an interview with the Nurse Manager, he stated staff must date the opened Lispro insulin vial and discard it within 28 days from the opening date. He stated staff must discard medications that belonged to discharged residents, and staff should not leave them in the medication fridge.</p> <p>The findings for the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. On [DATE] at 1:30 pm, during observation of medication cart in the 100 hall, a multivitamin bottle was open and not dated. The bottle belonged to R #43.</p> <p>G. Record review of R #43's face sheet, dated [DATE], revealed R #43 was discharged from the facility on [DATE].</p> <p>H. On [DATE] at 1:30 pm, during an interview with CMA #2, he stated the multivitamin bottle belonged to R #43 who was discharged on [DATE]. He stated he should have removed R #43's medications from the medication cart.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35632</p> <p>Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner when staff failed to:</p> <ul style="list-style-type: none"> - Store opened food with labels and dates to prevent cross contamination and outdated usage, - Store meat in a manner to prevent leakage and contamination of other food items, <p>These failures had the potential to result in cross contamination and foodborne illness which could affect all residents who ate food from the kitchen. The findings are:</p> <p>A. On 11/25/24 at 7:53 am, observation during a walk-through of the kitchen refrigerator revealed the following: that multiple items were either not dated or were past the date to be served and should have been thrown out.</p> <ul style="list-style-type: none"> - Unidentified sandwiches did not have a label on them. - Mashed potatoes with a date of 11/19/24 and use by 11/24/24. - Egg salad with unclear dates written on the label. - Sliced cheese was partially wrapped and was hard and discolored. - Container of deli ham not sealed. - A large container of leftovers was not labeled and dated. - Ham stored in a cardboard box sat on a shelf above a large container of unidentified, undated leftovers. Juice from the ham leaked onto the foil which covered the leftovers. <p>B. On 11/25/24 at 8:00 am, during an interview with Kitchen Assistant #2, he stated he removed a tray of unlabeled food, and there was more food in the refrigerator that was not labeled properly. He stated the juice on top of the leftovers was from the ham sitting on the shelf above it. He stated the ham was not stored properly and leaked through the box.</p> <p>C. On 12/02/24 at 11:32 am, the Kitchen Manager said all of his staff knew better than to leave the kitchen the way the staff found it after the weekend. He said they must have been in a rush to leave.</p> <p>D. On 12/02/24 at 11:40 am, during an interview with the Interim Registered Dietician, she stated she did a sanitary audit of the kitchen on 11/19/24. She stated she found unlabeled food in the refrigerator.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Canyon Transitional Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51919</p> <p>Based on observation and staff interview, the facility failed to maintain proper infection prevention practices when a staff did not perform hand hygiene prior to and after handling medications for 1 (R #132) of 1 (R #132), This deficient practice could likely result in the spread of infectious agents (viruses and bacteria) between the 23 residents in 100 hall. The findings are:</p> <p>A. On 11/25/24 at 9:53 am, during an observation of Nurse #1, she did not perform hand hygiene (a general term that applies to hand washing, antiseptic handwash, and alcohol-based hand rub) prior to administering medications to R #132.</p> <p>B. On 11/25/24 at 9:55 am, during an interview with Nurse #1, she stated she should have performed hand hygiene prior to and after administering medications to R #132.</p>