| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325054 | A. Building<br>B. Wing | 02/27/2026 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review, and interview, the facility failed to ensure food was prepared, served, handled, and monitored under sanitary conditions when staff failed to: Complete required daily logs of the sanitizer bucket, three compartment sink, and the dish machine in the kitchen.Complete daily refrigerator and freezer temperature logs in the nourishment room. Properly seal and protect open food items to prevent air exposure inside the large refrigerator located in the kitchen. Properly store raw meat inside the large refrigerator located in the kitchen. Wear gloves and avoid bare hand contact with ready-to-eat food while obtaining food temperaturesThese deficient practices are likely to affect all 68ˆresidents listed on the resident census list provided by the Administrator on 02/23/26 and is likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: Incomplete Logs:<br><br>A. Record review of the facility's Sanitizer Bucket Log (used to document that sanitizing solutions in wiping-cloth buckets are tested to ensure the proper concentration for disinfecting food preparation surfaces) dated February 2026, revealed the log was not documented as completed on 02/01/26, 02/07/26, and 02/08/26.<br><br>B. Record review of the facility's Three-Compartment Sink Log (used to document how the wash, rinse, and sanitizing sink compartments are maintained at appropriate temperatures and sanitizer concentrations, to ensure proper manual dishwashing and sanitization of food-contact equipment and utensils) dated February 2026, revealed the log was documented as completed for only one day (02/18/26) during the time frame of 02/07/26 through 02/22/26.<br><br>C. Record review of the facility's Dish Machine Log (used to document the mechanical dishwashing machine is operating at the appropriate wash and rinse temperatures and/or sanitizer levels to ensure proper cleaning and sanitization of dishes and food-contact equipment) dated February 2026, revealed the log was not documented as completed on 02/07/26, 02/08/26, and 02/16/26.<br><br>D. Record review of the facility's refrigerator and freezer temperature logs (used to ensure cold food storage equipment is maintained at safe temperatures to prevent food spoilage and bacterial growth), dated February 2026 in the nourishment room, revealed the logs had not been documented as completed from 02/14/26 through 02/26/26.<br><br>E. On 02/26/25 at 11:55 am, during an interview, the District Dietary Manager (DDM) stated kitchen staff were responsible for completing all logs. She acknowledged the sanitizer bucket, three compartment sink, the dish machine, the nourishment room refrigerator, and nourishment freezer logs were not completed and stated they should be.<br><br>Improper Food Storage and Protection from Contamination:<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | F. On 02/23/25 at 8:32 am, observation of the kitchen revealed the following:^<br><br>One small box of crab cakes was open and exposed to the air inside of the large freezer.<br><br>One medium package of raw meat was stored above a tray of prepared pudding cups on a speed rack (a tall, open-frame metal cart designed to vertically store, cool, or transport multiple sheet pans) inside the large refrigerator.<br><br>G. On 02/26/25 at 11:30 am, observation of the kitchen revealed one medium box of corn was open and exposed to the air inside the large freezer.<br><br>H. On 02/26/25 at 11:55am, during an interview, the DDM stated it was her expectation all food would be properly stored and not be exposed to air. She stated all meats should not be stored above any prepared foods. The DDM further stated it was her expectation all kitchen staff would adhere to these standards as they had all been trained in safe food handling and identified E.coli (bacteria spread by consuming contaminated food) as a possible risk to residents as a result.<br><br>I. On 02/27/26 at 12:54 PM, during a lunch test tray observation, the lunch test tray consisted of a chicken sandwich, mixed vegetables (broccoli, cauliflower, and carrots), and pineapple. The Dietary Manager (DM) was observed obtaining the temperature of the chicken sandwich with a digital thermometer while not wearing gloves and touched the bun of the sandwich with her bare hands.<br><br>J. On 02/27/26 at 1:16 PM, during an interview, the DDM stated it is her expectation gloves are to be worn while obtaining any temperature of food, and food should not be touched with bare hands. The DDM stated this could lead to transmission of bacteria to food, which could make residents ill.^ |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on record review and interviews, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of at least 12 hours per year for 4 (CNAs #12, #13, #16 and #17) of 7 (CNAs #11, #12, #13, #14, #15, #16, and #17) CNAs randomly reviewed for required in-service training. This deficient practice is likely to result in CNA's not receiving the necessary training to meet the care needs of the residents. The findings are:ˆ A. Record review of the facility Certified Nursing Assistants (CNA) staffing and training log indicated the following:ˆ CNA #12 was hired on 03/24/25. CNA #12 only completed 7 hours 52 minutes of in-service training and did not complete at least 12 hours of required in-service training.CNA #13 was hired on 09/30/24. CNA #13 only completed 4 hours 11 minutes of in-service training and did not complete at least 12 hours of required in-service training.CNA #16 was hired on 04/22/15. CNA #16 only completed 4 hours 44 minutes of in-service training and did not complete at least 12 hours of required in-service training.CNA #17 was hired on 05/30/24. CNA #13 only completed 5 hours of in-service training and did not complete at least 12 hours of required in-service training. B. On 02/26/26 at 2:58 pm, during an interview, the Director of Nursing (DON) stated this facility has never had a nurse educator, but the facility hired one and she will start soon. The DON stated she and the Unit Manager have been managing the education for each CNA. The DON confirmed CNAs #12, #13, #16, and #17 did not complete at least 12 hours of required in-service training and should have. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, interviews, and record review, the facility failed to develop an accurate comprehensive, person-centered care plan for 1 (R #30) of 2 (R #1 and #30) residents reviewed for care planning, when facility staff failed to initiate a care plan to reflect R #30's behavioral health needs, including Suicidal Ideation (SI; thoughts, preoccupations, or plans about ending one's own life, ranging from fleeting considerations to detailed planning). This deficient practice is likely to result in residents being at risk for unmet needs, a decreased quality of life, and avoidable decline in physical and psychosocial well-being. ˆ The findings are:ˆ A. Record review of R #30's face sheet revealed an admission date of 01/18/26.ˆ B. Record review of R #30's nursing progress notes revealed the following: Dated 01/19/26 at 11:25 am: R #30 made a comment about hurting herself to staff. Nurse and supervisor followed up with resident and R #30 denied active suicidal ideation, stating she was frustrated when she said that she would hurt herself. R #30 further stated she previously lived alone and had not acted on these impulses and that she didn't think she would be able to follow through with hurting herself. Dated 01/20/26 at 12:34 pm: Interdisciplinary team (IDT; a group of professionals from various fields working together to achieve a shared goal) review of orders including a new order for psychiatric services, as soon as possible (ASAP) related to R #30's Suicidal Ideation. Dated 01/21/26 at 10:16 am: Mood and behavior note: R #30 anxious this morning, verbalized she is supposed to be in a different place not at facility and wants to go home.ˆ Dated 01/21/26 at 5:15 pm: Since the last evaluation, behavior symptoms have increased; R #30 is not sleeping good at night due to insomnia (difficulty falling asleep or staying asleep).ˆ C. Record review of R #30's Brief Cognitive Assessment Tool (BCAT; a structured instrument developed to evaluate cognitive function, cognitive skills, and cognitive impairments) dated 01/20/26, revealed R #30 has a Total BCAT Score of 20 (a BCAT score of 44 or higher is considered normal, while scores below 44 may indicate mild cognitive impairment or dementia). R #30's BCAT score indicates R #30 has cognitive impairment and/or dementia. D. Record review of R #30's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 01/22/26 revealed the following:ˆ R #30 has a diagnosis for Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).R #30 reported little interest or pleasure in doing things 2 to 6 days over the past two weeks. R #30 reported feeling down, depressed, or hopeless 7 to 11 days over the past two weeks. R #30 reported feeling bad about herself or that she is a failure or has let her family down 12 to 14 days over the past two weeks. R #30 reported having trouble concentrating on things, such as reading the newspaper or watching television. R #30 reported moving or speaking so slowly that other people have noticed or has been so fidgety or restless that she has been moving around a lot more than usual. R #30 sometimes feels lonely or isolated from others. R #30's Patient Health Questionnaire 2 to 9 (PHQ2-9; tools used for screening and diagnosing depression) Total Severity Score of 10 (1 to 4 equals minimal depression; 5 to 9 equals mild depression; 10 to 14 equals moderate depression; 15 to 19 equals moderately severe depression; and 20 to 27 equals severe depression), indicating R #30 was experiencing moderate depression. E. Record review of R #30's Care Plans dated 01/25/26, revealed a care plan was not developed for R #30's dementia related behaviors or psychiatric service needs.ˆ F. On 02/25/26 at 11:23 am during an observation of R #30, she was observed sitting in her room alone. R #30 declined to be interviewed, but signs of emotional withdrawal (act of distancing oneself from emotional engagement) was present. ˆ G. On 02/27/2026 at 2:17 pm during an interview, the Director of Nursing (DON) stated R #30's care plan should have been developed to address R #30's behavioral concerns and Suicidal Ideation (SI). The DON confirmed R #30's care plan was not developed to address behaviors, including SI. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to revise a care plan for 1 (R #70) of 1 (R #70) resident reviewed for feeding tube (medical device to provide nutrition to people who cannot obtain nutrition by mouth) use. If the facility is not updating the care plan to reflect the residents' current care areas and treatment, then the facility may not be providing the appropriate care and treatment to meet the residents' needs. The findings are: A. Record review of R #70's face sheet revealed R #70 was admitted into the facility on [DATE] with the following diagnoses:ˆ Dysphagia (difficulty with swallowing food or liquid),Aphasia (disorder that results from damage, usually from a stroke or traumatic brain injury to areas of the brain that are responsible for language),Malnutrition (imbalance between the nutrients your body needs to function and the nutrients your body gets). B. Record review of R #70's nursing progress notes dated 02/04/26 revealed the following: R #70 was sent to the hospital due to poor nutritional status from resident having dysphagia. R #70's poor intake was causing his wounds to not heal properly. R #70 had a Fiberoptic Evaluation of Swallowing (FEES test helps detect aspiration, swallowing difficulties, and other dysphagia-related issues) indicating a risk of silent aspiration (hidden risk of fluid entering the lungs without a cough). Facility was asking the hospital for an assessment for possible feeding tube placement for R #70 to receive proper nutrition. ˆ C. Record review of R #70's nursing progress notes dated 02/12/26 revealed R #70 was readmitted into the facility on [DATE] with a feeding tube.ˆ D. Record review of R #70's physician orders dated 02/13/26 revealed the following: Enteral (tube) feed every day and night shift, flush tube with 30 milliliters (ml) of water prior to feeding, 45 ml per hour during continuous feeding, and a 30 ml flush of water at the end of each feeding. Nothing by mouth (NPO). E. Record review of R #70's care plan dated revealed the following: Dated 01/01/26: Focus: Impaired swallowing related to stroke. Interventions: Provide assistance during meals, resident will be at 90 degrees upright position when swallowing food or drink, encourage small sips and bites and cue as needed, encourage resident to chew and swallow each bite, and encourage resident to alternate liquids and solids. This care plan focus was current as of 02/27/26.ˆDated 02/23/26: Focus: Enteral feeding tube to meet nutritional needs. Interventions: Check patency and placement of the tube daily, formula per medical doctor protocol, feeding tube changes per order, head of bed elevated 30 to 45 degrees during feeding, and monitor for nausea, vomiting, diarrhea, cramping fatigue, weakness, and vital signs.ˆR #70's care plan was not updated to remove the impaired swallowing with dining assistance interventions. F. On 02/27/26 at 12:08 pm, during an interview, the Director of Nursing (DON) stated if the impaired swallowing care plan focus was no longer relevant for R #70, then it should show as resolved and no longer be active on R #70's care plan. The DON stated since R #70 used a feeding tube, there should not be a care plan present for feeding assistance. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to prevent a significant medication error for 1 (R #84) of 1 (R #84) resident reviewed, when:The facility administered Tylenol (acetaminophen; pain medication) without a manufacturer's expiration date or date of opening on bottle. This deficient practice is likely to result in residents not receiving full benefit from medications, possible prolonged treatment period, or unwanted effects. The findings are: A. On [DATE] at 8:39 AM, during an observation of R #84's medication administration, Certified Medication Aide (CMA) #1 prepared R #84's Tylenol for administration. There was no observed expiration or opening date printed on the Tylenol bottle or label. CMA #1 administered Tylenol to R #84. B. On [DATE] at 8:40 AM, during an interview, CMA #1 stated over the counter medications (OTC; medications sold to individuals without a prescription) like Tylenol, can be used for 30 days after opening. CMA #1 stated all bottles should have a manufacturers expiration date present with a date the bottle was opened by staff. CMA #1 verified no manufacturer expiration date or date of opening was placed on the bottle, and stated if used residents could get sick, or have stomach related issues. CMA #1 stated he should have obtained a new bottle and not used the bottle which did not have a manufacturer expiration date or date of opening present. C. On [DATE] at 1:27 PM during an interview with the Director of Nursing (DON), she stated during medication administration of OTC medications it is her expectation the staff check the expiration date on the bottles of medication. The DON further stated it is her expectation, if an OTC medication does not have an expiration date, it should not be used, and a new bottle should be obtained. The DON stated if a medication without an expiration date is used, it could be expired, and result in medication being less effective or possibility of residents becoming ill. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain a safe and sanitary environment to prevent the transmission of infectious agents and communicable diseases for 2 (R #4, and R #43) of 2 (R #4, and R #43) residents, when the facility: Failed to prevent a urinary catheter (a thin, flexible tube which drains urine from the bladder) bag and tubing from touching the floor for R #4. Placed an oxygen humidification container (device used to add moisture to dry oxygen gas before it is delivered to a patient) on the floor of R #43's room. ˆThese deficient practices have the potential to expose staff and other residents to infectious diseases. ˆThe findings are: R #4:<br><br>A. Record review of the facility's Catheter Care Procedure (steps to maintain the catheter and drainage system), last revised on 01/15/26, revealed staff were required to secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor.<br><br>ˆ<br><br>B. Record review of R #4's face sheet revealed R #4 was originally admitted into the facility on [DATE] with a diagnosis of chronic kidney disease (CKD; impaired kidney function).<br><br>ˆ<br><br>C. Record review of R #4's physician orders revealed an active order, dated 02/17/26, for an indwelling catheter (a thin, flexible tube which drains urine from the bladder).<br><br>ˆ<br><br>D. On 02/25/26 at 11:57 am, during a dining room observation, R #4 was seated in a wheelchair eating lunch. The observation revealed R #4's urinary catheter drainage bag and attached tubing was hanging from the wheelchair and was in contact with the floor.<br><br>ˆ<br><br>E. On 02/27/26 at 9:35 am, during an interview, the Director of Nursing (DON) stated catheter bags should be positioned under the resident's wheelchair and not touching the floor. The DON also stated staff are expected to ensure proper positioning and identified infection as a potential hazard if a catheter bag touches the floor.<br><br>R #43:<br><br>F. On 02/23/26 at 10:50 am during an observation of oxygen use for R #43, an oxygen humidification container (refillable container attached to oxygen concentrators to add moisture to the oxygen) connected to a nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs), was on the floor of R #43's room.<br><br>G. Record review of R #43's physician orders dated 02/12/26, revealed for oxygen use of 1 to 6 liters per minute via nasal cannula, continuously every day and night for Chronic Obstructive Pulmonary Disease (COPD; lung disease).<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | H. On 02/23/26 at 3:30 pm during a repeat observation of R #43's oxygen equipment, R #43's oxygen humidification container remained on the floor of R #43's room.<br><br>I. On 02/23/26 at 3:34 pm during an interview, Licensed Practical Nurse (LPN) #1 stated oxygen humidification should not be placed on the floor as it is an infection control issue, which could lead to residents becoming ill.<br><br>J. On 02/27/26 at 10:11 am, during an interview, the Director of Nursing (DON) stated it is her expectation R #43's oxygen equipment should not be placed on the floor. The DON also stated if a resident's oxygen humidification container is placed on the floor, it poses a risk of infection for the resident. |