STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325060	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odelia Healthcare	1509 University Boulevard NE Albuquerque, NM 87102

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record reviews and interviews, the facility failed to provide a qualified interpreter for 1 (R #7) of 1 (R #7) residents reviewed. If a facility fails to provide interpreter services, then residents with limited English proficiency may not be able to fully understand their care plan, ask questions about their treatment, or communicate their needs effectively to staff. The findings are:A. Record review of the facility's Interpreter Services policy, dated 2003, revealed all nursing home staff with a second language ability will be identified and utilized as interpreters, as needed, to ensure non-English speaking residents can convey their needs and preferences. B. Record review of R #7's admission Record revealed an admission date of 06/14/2025. C. Record review of R #7's Care Plan, dated 06/27/2025, revealed the resident had a communication problem related to Spanish speaking. D. On 08/27/2025, at 2:33 PM, during an interview, R #7's daughter stated her father was primarily Spanish-speaking, and the facility did not provide interpreter services for her father. The daughter stated she had frequent issues caused by lack of communication regarding R #7's abdominal pain, urinary problems, and frustration over inadequate care. E. On 08/27/2025, at 5:53 PM, during an interview, R #7's spouse stated the facility did not provide interpreter services for her husband during his stay. She stated her husband had difficulty communicating concerns about his lack of urine output and inconsistent monitoring by staff. She stated the lack of interpreter services caused confusion and inadequate care. F. On 09/04/2025, at 10:08 AM, during an interview, the Social Services Assistant (SSA) stated interpreter services were not arranged for R #7 during his stay, and interpretation was primarily done by his family members present at his bedside. G. On 09/03/2025 at 2:59 PM, during an interview, the Director of Nursing (DON) stated R #7 was Spanish speaking only, and the lack of an interpreter could lead to miscommunication and affect the resident's quality of care.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record reviews and interviews, the facility failed to ensure the resident's MDS (MDS; a federally mandated assessment instrument completed by facility staff) was accurately coded for 1 (R #7) of 1 (R #7) residents reviewed. If the facility fails to ensure the Federally mandated MDS is accurately coded for residents, then the facility cannot develop appropriate care plans or provide individualized treatment, which places residents at risk for unmet needs, delayed interventions, and adverse health outcomes.The findings are: A. Record review of R# 7's Hospital Discharge Orders, dated 06/14/2025, revealed the following: -Resident to receive wound care for hematuria (presence of blood in the urine). -Resident to receive physical occupational therapy for hematuria. B. Record review of R #7's admission Record, dated 06/14/2025, revealed the following: -admission date of 06/14/2025. -Diagnosis of metabolic encephalopathy (a reversable brain disorder of the body's chemicals). -The record did not include a diagnosis of hematuria. C. Record review of R #7's admission MDS (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/17/2025, revealed the record did not contain documentation of active diagnosis of hematuria. D. Record review of R #7's Change in Condition Evaluation, dated 06/19/25, revealed the following:-The resident had a significant decline in food and fluid intake.-The resident was tired, weak, confused, or drowsy. -The resident presented with increase confusion and generalized weakness. E. Record review of R #7's Hospital Discharge documentation, dated 06/21/2025, revealed the following: -Primary diagnosis of hematuria. -readmitted for hematuria. -Resident's plan of care for hematuria. F. Record review of R #7's Progress Notes, dated 06/26/2025, revealed the following:- Resident returned from the hospital for gross hematuria.- Nursing staff observed a small amount of blood in the resident's brief, and a urinalysis (UA; laboratory test on urine to detect infection) ordered.- Urinalysis not yet obtained. G. On 09/03/2025 at 10:23 AM during an interview, the MDS Coordinator stated the facility did not include R #7's gross hematuria diagnosis in the resident's MDS. The MDS Coordinator stated the resident's MDSs, dated 06/17/2025 and 06/26/2025, were correct. The MDS Coordinator stated resident symptoms were not included on the active diagnoses list if the facility was not treating the condition in house. H. On 09/03/2025 at 2:59 PM during an interview, the Director of Nursing (DON) stated R #7's diagnosis of a gross hematuria was not coded in the resident's MDS Assessment. The DON stated the MDS Coordinator was responsible to ensure R #7's diagnosis of a gross hematuria was included in the MDS.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on a record review and interviews, the facility failed to ensure a resident received care for a diagnosis included on their hospital discharge paperwork for 1 (R #7) of 1 (R #7) residents. If the facility fails to ensure all admitting diagnoses are included in the resident's plan of care, then staff may fail to monitor and treat the condition which could lead to the adverse outcomes or re-hospitalization. The findings are: A. Record review of R# 7's Hospital Discharge paperwork, dated 06/14/2025, revealed the following: - Diagnoses of hematuria (blood in the urine) attributed to traumatic Foley catheter insertion (injury or damage to the urethra, bladder, or surrounding tissue during Foley catheter)and urinary tract infections with hematuria.- Referrals to physical and occupational therapy.-Resident to receive care for hematuria (presence of blood in the urine). B. Record review of R #7's admission Record, dated 06/14/2025, revealed the following: -admission date of 06/14/2025. -Diagnosis of metabolic encephalopathy (a reversable brain disorder of the body's chemicals). -The record did not include a diagnosis of hematuria. C. Record review of R #7's Provider Progress Note, dated 06/16/2025, revealed the notes did not contain documentation of treatment for resident's admitting diagnosis of hematuria. D. Record review of R #7's Care Plan, dated 06/17/2025, revealed the care plan did not include the resident's admitting diagnosis of a hematuria. E. Record review of R #7's Minimum Data Set (MDS) assessment, dated 06/17/2025, revealed the MDS did not contain documentation of hematuria diagnosis. F. Record review of R # 7's Change in Condition Evaluation, dated 06/19/25, revealed the following: -Significant decline in food and fluid intake.-Seems different than usual.-Tired, weak, confused or drowsy.-Since the change of condition occurred the symptoms or signs have gotten worse.-Increase confusion.-General weakness. G. Record review of R #7's Hospital Discharge documentation, dated 06/21/2025, revealed the following: -Primary diagnosis of hematuria. -readmitted for hematuria. -Resident's plan of care for hematuria. H. Record review of R #7's Progress Notes, dated 06/26/2025, revealed the following:-Resident returned from the hospital for diagnosis of hematuria.-Nursing staff observed a small amount of blood in the resident's brief, and a urinalysis ordered.-Uranalysis not yet obtained. I. Record review of R #7's Provider Notes, dated 08/20/2025, r revealed the notes did not contain documentation of treatment for resident's admitting diagnosis of hematuria. J. Record review of R #7's Change of Condition Evaluation, dated 08/21/2025, revealed the following: -Urine retention. -Bladder scan greater than 999 milliliters (ml). -Attempted catheter insertion, unsuccessful due to severe resistance and severe pain. -Abdominal tenderness. -Persistent discomfort not associated with other acute symptoms. -Decreased urine output over one to two days. -Lower severe abdominal pain. K. On 09/03/2025 at 10:23 AM during an interview, the MDS Coordinator stated the facility did not include R #7's gross hematuria diagnosis in the resident's MDS. The MDS Coordinator stated resident symptoms were not included on the active diagnoses list if the facility was not treating the condition in house. L. On 09/03/2025 at 2:59 PM during an interview, the Director of Nursing (DON) stated staff did not document R #7's hematuria diagnosis in the resident's admission record, Care Plan, and MDS. The DON stated the MDS Coordinator was responsible to include R #7's hematuria diagnosis in the resident's MDS. The DON stated staff failed to complete the urinalysis as ordered by the provider. The DON stated it was her expectation for all residents' hospital diagnoses to be entered in the resident's MDS and care plan for appropriate care.