

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Albuquerque Heights Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Hospital Loop NE Albuquerque, NM 87109	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</b></p> <p>Based on record review and interview, the facility failed to honor residents' choices for 3 (R #8, R #16 and R #17) of 3 (R #8, R #16 and R #17) residents reviewed for choices when staff failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure showers in resident rooms were in working order (including missing faucet knobs and having random items stored in them), which caused R #8 to utilize the community shower only on scheduled days/times rather than choosing the days and times she preferred to shower.</li> <li>2. Ensure a female staff was available to provide showers per R #16 preference for female staff only for showers.</li> <li>3. Ensure there were clean towels available for resident showers.</li> </ol> <p>These deficient practices are likely to cause frustration and diminish quality of life. The findings are:</p> <p>Resident #8</p> <p>A. On 08/22/24 at 11:45 am, a random observation of resident shower in room [ROOM NUMBER] revealed there were items stored in the shower, and there was not a faucet knob on the shower.</p> <p>B. On 08/22/24 at 11:48 am during an interview, R #8 stated she would prefer to use the shower in her room if it were in working condition. She stated she has had to utilize the community shower, because the shower in her room was not usable. She stated the community shower room was not always available because the residents who required assistance with showers were scheduled to receive showers on certain days and times in the community shower room. She stated residents who were independent in their ADLs and did not have working showers in their rooms had to work around the scheduled showers in order to utilize the community shower rooms.</p> <p>C. On 08/22/24 at 2:49 pm during an interview, the Director of Nursing (DON) stated it was not acceptable to have random items stored in resident showers or to have showers with missing faucet knobs. She stated this rendered the showers unusable to residents who are independent in showering.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. On 08/23/24 at 12:23 pm during an interview, the Administrator (ADM) stated he was not aware there were items stored in showers or that there were showers that were not in working order due to missing faucet knobs. He stated that was not acceptable.</p> <p>Resident #16</p> <p>E. On 08/22/24 at 9:52 am during an interview, Family Member (FM) #2 stated R #16 preferred to have her showers done by female staff. FM #2 stated there was not always female staff available to assist with her showers so the resident would refuse to be showered by male staff.</p> <p>F. Record review of Daily Shower Tracking Sheet for R #16, dated 04/22/24, revealed the resident preferred female only, but the female Certified Nursing Aide (CNA) claimed she could not do it due to being on two halls.</p> <p>G. Record review of the Daily Shower Tracking Sheets for R #16 revealed the following:- On 04/18/24 - Resident refused, but staff did not document a reason.</p> <ul style="list-style-type: none"> <li>- On 04/19/24 - Resident refused, but staff did not document a reason. The sheet was signed by a male staff.</li> <li>- On 04/22/24 - Resident refused, female staff was not available.</li> <li>- On 04/23/24 - Resident refused, but staff did not document a reason. The sheet was signed by a male staff.</li> <li>- On 04/29/24 - Resident refused, but staff did not document a reason. The sheet was signed by a male staff.</li> <li>- On 05/13/24 - Resident refused, but staff did not document a reason.</li> <li>- On 05/21/24 - Resident refused, but staff did not document a reason.</li> <li>- On 06/18/24 - Resident refused, but staff did not document a reason.</li> <li>- On 06/21/24 - Resident refused, but staff did not document a reason.</li> </ul> <p>Resident #17</p> <p>H. On 08/23/24 at 9:29 am during a interview, FM #3 stated R #17 preferred to have her showers done by female staff and would refuse showers if a male staff was going to do the showers. She stated there were also several times when clean towels were not available for resident showers, and sometimes staff would use disposable wipes to clean R #17 rather than offering a bed bath. She stated that on one occasion, she went home and brought towels with her to the facility, She stated she assisted R #17 with a shower, because R #17 looked unclean (hair was greasy). She stated R #17 told her that she (R #17) felt demeaned and embarrassed.</p> <p>I. On 08/23/24 at 10:22 am during an interview, R #17 stated she requested showers on several occasions, but staff told her there were not any towels. She stated one of her family members brought towels on one occasion and showered her since there were not any clean towels available at the facility for resident showers.</p> <p>J. Record review of Daily Shower Tracking Sheets for R #17 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 06/13/24 - Resident refused, but staff did not document a reason. The sheet was signed by a male staff.</p> <p>- On 06/20/24 - Resident refused, but staff did not document a reason. The sheet was signed by a male staff.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35632</p> <p>Based on record review and interview, the facility failed to notify the physician or on call physician when facility staff had problems with a wound vacuum (wound vac; a type of therapy to help wounds heal, the device decreases air pressure on the wound and helps it heal more quickly.) functioning properly for 1 (R #3) of 2 (R #3 and R #18) residents reviewed for wound vac care. This deficient practice of not notifying the physician and receiving further orders on how to continue with wound care could cause the wound to worsen or become infected. The findings are:</p> <p>A. Record review of the face sheet for R #3 revealed she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>- Third degree burns (a serious injury that destroys all three layers of the skin: the epidermis, dermis, and hypodermis) of multiple sites on the right lower leg, foot, and ankle;</li> <li>- Seizures;</li> <li>- Cellulitis (serious bacterial infection of the skin) of right lower limb.</li> </ul> <p>B. Record review of the discharge hospital orders for R #3, dated 06/01/24, indicated R #3 was discharged from the hospital to the facility with an order for wound care. Order: First, second, and fourth toes covered with Santyl (medication used to treat severe burn or skin ulcers by removing dead skin tissue and aid in wound healing) and tegaderm (a transparent film-type wound dressing which shields the injury from water, dirt, and germs while allowing the wound to breathe.) Recommend changed daily by the facility floor staff. Plan for Registered nurse wound care (RNWC) to follow-up on 06/02/24 to 06/03/24 for another dressing change. Wound vacuum settings are negative pressure wound therapy (NPWT; a treatment that uses suction to help wounds heal) set to 125 millimeters of mercury (mmHg; a unit of pressure; a setting for the machine) on continuously.</p> <p>C. On 08/22/24 at 11:45 am, during an interview with R #3's daughter, she stated her mother was at the hospital with 3rd degree burns to her lower leg, ankle, and foot. She stated her mother had a skin graft done on her right lower leg. She said her mother was discharged from the hospital to the facility on [DATE], and when she arrived at the facility they took the dressing off so they could take pictures of the wounds. She stated the facility staff could not get the wound vac to work properly, and they tried for hours. She stated the facility left the same dressing on with the machine beeping and not working. The daughter stated if the wound vac is not working after a couple of hours then it has to be removed and a different dressing applied.</p> <p>D. Record review of a progress note for R #3, dated 06/02/24 at 10:20 am, revealed a right lower extremity (RLE) wound with wound dressing (wound vac) in place but not working. Send script for Dilaudid (an opioid pain medication for moderate to severe pain), 2 milligrams (mg) by mouth for dressing change. Change dressing 30 to 40 minutes after the Dilaudid was given.</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 - Few</p>	<p>E. Record review of a progress note for R #3, dated 06/02/24 at 12:20 pm, indicated the resident's wound vac was malfunctioning. Nurse called to report the wound vac to right lower leg was not working and was leaking from the dressing. The nurse kept the wound vac turned off since the morning. The resident continued in extreme pain to the wound. The resident took an extra dose of oxycodone (pain medication) one time early this morning and has been on her as needed (PRN) oxycodone timely, without significant relief of the pain. The resident understood and agreed to change the dressing and requested a one time dose of Dilaudid. Reviewed the hospital record for pain management and noted the resident took a low dose of intravenous (IV; directly into a vein) Dilaudid at the hospital.</p> <p>F. Record review of the nursing progress notes for R #3, dated 06/02/24 at 1:47 pm, revealed When I came on this morning, per night shift nurse (name of nurse) that wound vac machine attached to right leg wound has been beeping and night nurse was not able to fix the issue. I went to check on patient [pt] after report and narcotic count. Pt was lying in bed, observed upset, and annoyed by the constant beeping sound of wound vac machine. Stated she did not sleep and the pain meds were late when previous nurses did her wound vac twice and the beeping continuous [sic]. I told pt that the machine need to be turned off, give her a extra dose of oxycodone 10 mg for pain, she said it will not work and I don't want the wound reopened again, they just did it twice last night and it is painful .</p> <p>G. Record review of the resident's medical record revealed the record did not contain documentation staff notified the resident's doctor that the wound vac malfunctioned.</p> <p>H. On 08/23/24 at 9:05 am, during an interview with Nurse #5, she stated R #3 came in on the end of her shift. She stated R #3 came in with the wound vac dressing and tubing in place, but there was no wound vac attached. She stated the tubing that the hospital attached to the dressing did not work with the wound vac they had at the facility. The nurse stated she took some pictures of the wounds and then went home. She stated the night shift took over when she left, and she was not sure what happened after that.</p> <p>I. On 08/22/24 at 1:27 am, during an interview with Nurse #4, she stated she was aware R #3's wound vac had to be changed because it was not working. She stated sometimes the tubing they have at the facility did not work well, and the wound vac could get clogged if the tubing was too thin. She stated it could be hard to get the wound vac to suction properly. She stated nursing staff can always do a regular dressing with orders from the physician, if there are problems with the wound vac.</p> <p>J. On 08/23/24 at 10:58 am, during an interview with Nurse #6, she stated the wound vac machine was on and beeping when she first went into R #3's room. Nurse #6 stated if the machine was beeping then it was not working properly. She stated the wound vac should not stay on longer than two hours before it needed to be taken off and a different dressing applied. She stated a wet to dry gauze (type of wound dressing that uses wet gauze or packing tape to remove drainage and dead tissue) would have been appropriate, and staff should have done that. Nurse #6 stated the nurse on duty should have notified the physician when she realized the wound vac was not functioning and she could not get it to suction properly.</p> <p>K. On 08/23/24 at 10:30 am, during an interview with Unit Manager, she stated she did not see documentation in R #3's medical record that the night nurse on 06/01/24 to 06/02/24 called the on call physician about the wound vac issues that were occurring.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40671</p> <p>50752</p> <p>Based on observation and interview, the facility failed to provide a homelike environment for all residents on the 300 units (residents were identified by the resident census provided by the Administrator on 08/19/24) when they failed to:</p> <ol style="list-style-type: none"> <li>1. Repair damaged and broken blinds in rooms 302, 307, 308, 314, 322, and 325.</li> <li>2. Repair a damaged thermostat that controlled the 300 unit.</li> <li>3. Repair 11 broken floor tiles and broken toilets in the shower room.</li> <li>4. Ensure handrails were secured to the wall.</li> <li>5. Repair four outlet faceplates on the 300 unit which were loose and not secured.</li> <li>6. Ensure bed frames were not stored in the 300 Hallway.</li> <li>7. Ensure there were enough towels available for the residents during showers.</li> <li>8. Repair areas in 12 resident rooms with unpainted patchwork.</li> <li>9. Repair missing faucet knobs, running faucets, broken blinds, sticky floors, and ensure random items, including medical equipment, were not stored in resident showers.</li> </ol> <p>These deficient practices could likely result in residents feeling frustrated, embarrassed, and unimportant. The findings are:</p> <p>Broken Blinds</p> <p>A. On 08/19/24 at 10:05 am, during observation, Rooms #302, 306, 307, 308, 314, 321, 322, and 325 were occupied by residents and had broken blinds.</p> <p>B. On 08/23/24 at 01:15 pm, during an interview with the Maintenance Director (MD), he stated he knew about some of the broken blinds. He stated he only had time to check a few rooms for issues. He said staff need to put in a work order. He stated he did not randomly go into resident rooms and check them.</p> <p>Thermostat</p> <p>(continued on next page)</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>C. On 08/19/24 at 10:15 am, during observation of the main sitting room on the 300 unit, the thermostat was damaged, hung by the wires, and had old scotch tape falling off the wall around it. Upon further inspection, it was noted that the enclosure containing the thermostat lacked a locking mechanism and had exposed wiring.</p> <p>D. On 08/23/24 at 1:15 pm, during an interview with the MD, He stated he was aware of the thermometer which hung of the wall in the 300 unit sitting room. He explained the key to the unit was broken, and someone ripped the thermostate cover off the wall. The MD stated they taped it back on the wall with scotch tape. The MD stated it was unacceptable.</p> <p>Shower Rooms</p> <p>E. On 08/19/24 at 09:31 am, during observation, the shower room in the south wing had 11 missing tiles.</p> <p>F. On 08/19/24 at 09:32 am, during observation, the toilet in the shower room on the 300 unit had dried feces and no water.</p> <p>G. On 08/20/24 at 09:32 am, during an interview, Certified Nursing Assistant (CNA) #4 stated the toilet in the shower room had been malfunctioning for almost three months. She stated the staff usually just put a trash bag over it, so no one used it. She stated she thought there was a work order for it, but she was not sure. CNA #4 stated, It is just gross.</p> <p>H. On 08/23/24 at 1:15 pm, during an interview, the MD stated the toilet in the shower room was clogged, and maintenance fixed the problem. He stated he was not aware the toilet had dried feces and no water, because the nurses did not put in a work order.</p> <p>Handrails 300 Unit</p> <p>I. On 08/19/24 at 09:25 am, during the observation of the 300 hall, three handrails were insecurely attached to the wall. The handrails were loose and moved when touched.</p> <p>J. On 08/23/24 at 1:15 pm, during an interview with the MD, he stated he was aware of the loose handrails but did not fix them yet.</p> <p>Outlet Faceplates:</p> <p>K. On 08/19/24 at 09:30 am, during observation, four outlet faceplates in the common areas were not securely fastened.</p> <p>L. On 08/23/24 at 1:15 pm, during an interview with the MD, he stated he did not have any work orders for the faceplates, and the loose face plates posed a safety hazard.</p> <p>300 Unit Halls:</p> <p>M. On 08/19/24 at 09:43 am, during observation, the south hall contained an unoccupied bed frame without a mattress.</p> <p>(continued on next page)</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>N. On 08/23/24 at 1:15 pm, during an interview with the MD, he stated he did not have any work orders to remove the bed frame.</p> <p>Linen:</p> <p>O. On 08/23/24 at 10:00 am, during observation, the linen closet in the 100 unit did not have an adequate supply of towels and sheets for the entire facility. The linen closet in the 200 unit contained towels and sheets, but the quantities were insufficient for the entire facility. The linen closet in the 300 unit did not have towels and sheets. This resulted in residents not having access to clean towels or sheets as needed.</p> <p>P. On 08/23/24 at 12:25 pm, during an interview with Assistant Administrator, she stated she was aware of the shortage of towels and sheets.</p> <p>Unpainted Walls</p> <p>Q. On 08/19/24 at 10:00 am, during observation of the 300 units, it was found that twelve rooms had areas with unpainted patchwork on the walls.</p> <p>R. On 08/23/24 at 1:15 pm, during an interview the MD stated he did not get to the unfinished and unpainted room walls, because he had been busy.</p> <p>Resident Rooms</p> <p>R. On 08/22/24 at 11:45 am, an observation of resident room [ROOM NUMBER] revealed the shower did not have a faucet knob.</p> <p>S. On 08/22/24 at 11:46 am, an observation of resident room [ROOM NUMBER] revealed the sink dripped constantly.</p> <p>T. On 08/22/24 at 11:47 am, an observation of resident room [ROOM NUMBER] revealed a hoier lift sling hung from the faucet knob in the shower, and there was a hole in wall from the bathroom door handle.</p> <p>U. On 08/22/24 at 11:48 am, an observation of resident room [ROOM NUMBER] revealed the sink leaked nonstop, and there was an IV stand and two buckets stored in the shower.</p> <p>V. On 08/22/24 at 11:52 am during an interview, R #8 stated she and her roommate did not receive anything through an IV. She stated she did not know why there was stuff stored in the shower or who the stuff belonged to. She further stated the sink had been leaking nonstop for months. She stated it was reported many times, but it was not repaired.</p> <p>W. On 08/22/24 at 12:32 pm, an observation of resident room [ROOM NUMBER] revealed the water in the sink ran nonstop, there was not a knob for faucet in the shower, there was a wheelchair stored in the shower, the window blinds were broken, and the floor throughout the entire room was sticky.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35632</p> <p>Based on interview and record review, the facility failed to keep a resident free from abuse for 1 (R #2) of 3 (R #2) residents reviewed for abuse when Certified Nurse Aide (CNA) was verbally and physically abusive to R #2 when providing care. This deficient practice likely resulted in emotional distress and trauma for R #2. The findings are:</p> <p>A. Record review of the face sheet for R #2 revealed the following:</p> <ul style="list-style-type: none"> <li>- Schizophrenia (mental health disorder that affects an individual's ability to think, feel, and behave clearly),</li> <li>- Alzheimer's disease (a group of symptoms that affects memory, thinking and interferes with daily life),</li> <li>- Disruptive mood dysregulation disorder (causes chronic, intense irritability and frequent angry outbursts),</li> <li>- Cognitive communication deficit (communication difficulty),</li> <li>- Anxiety,</li> <li>- Depression,</li> <li>- Metabolic encephalopathy (change in how your brain works due to an underlying condition).</li> <li>- This is not an all inclusive list.</li> <li>- R #2 was initially admitted to the facility in 01/09/18.</li> </ul> <p>B. On 08/23/24 at 1:23 pm, during an interview with R #2, she stated she remembered CNA #5 yelled at her and pulled her hair. She stated she felt scared, like she was in trouble. She stated she felt fine now because no one was pulling her hair.</p> <p>C. Record review of the care plan for R #2, last revised on 03/11/22, indicated she had the potential to demonstrate verbal behaviors related to cognitive loss/dementia, schizophrenia, anxiety, history of verbal outbursts directed toward others, pseudobulbar affect (a neurological condition that causes people to have sudden, uncontrollable, and inappropriate episodes of abusive language, challenging or confrontational verbal behavior, hitting, scratching, resisting care.)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Albuquerque Heights Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  103 Hospital Loop NE Albuquerque, NM 87109	
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 08/21/24 at 3:42 pm, during an interview with CNA #6, she stated she was asked to work a few hours on the evening/night shift on 06/01/24 and she did. She stated CNA #5 asked her to assist with putting residents to bed during the evening/night shift. CNA #6 stated when they started to take R #2 to bed, the resident became upset and started to yell things like fuck you, bitch and whore. CNA #6 stated CNA #5 yelled back at R #2, and that made R #2's behaviors worse. CNA #6 stated when they got to R #2's room, she (CNA #6) went around to the far side of the resident's bed so she could control the bed. CNA #6 stated she heard a smack at one point and saw CNA #5 pulling away from R #2's knee. She stated she did not see CNA #5 hit R #2, but she saw CNA #5's hand pulling away and heard the noise of a smack. CNA #6 stated R #2 and CNA #5 continued to yell at each other, and she heard CNA #5 yell I hate you, too and Fuck you, too. CNA #6 stated she saw R #2 swing at CNA #5. CNA #6 stated she came around the bed to help with the resident, and she saw CNA #5 pulling R #2's hair. She stated CNA #5 had a fist full of the resident's hair and was pulling it straight up towards the ceiling. She said R #2 was screaming. CNA #6 stated she could not believe it. CNA #6 said she did not say anything to CNA #5 at this time, she felt like it would escalate the situation and just wanted to go and report it. CNA #6 stated she tried to make sure R #2 was safe in bed before she left the room. CNA #6 said she was going to leave the room, but CNA #5 told her to raise up the resident's bed. CNA #6 stated she turned around to grab the bed remote, and CNA #5 cursed at R #2. CNA #6 stated she witnessed CNA #5 put both hands on R #2's arms and pushed her down on the bed. She stated CNA #5 yelled, I fucking hate you. CNA #6 stated she immediately left the room, went and reported it to the nurse. She stated the nurse reported it to the weekend Unit Manger. She stated CNA #5 left the facility shortly after the incident. CNA #6 stated she went back to R #2's room, checked on the resident, and gave her some comfort. She stated R #2 seemed ok.</p> <p>F. On 08/22/24 at 12:11 pm, during an interview with Unit Manager #2, she stated she received a call from CNA #6 on 06/01/24. She stated CNA #6 told her she was helping to change R #2 when she saw CNA #5 abuse R #2. UM #2 stated CNA #6 told her in detail what she saw. UM #2 stated she called the nurse supervisor as soon as she got off the phone with CNA #6 and told him to suspend CNA #5 immediately. UM #2 stated the nurse supervisor suspended CNA #5.</p> <p>G. On 08/22/24 at 9:40 am, during an interview with the Administrator, he stated the UM #2 notified him of the incident and what happened. He stated CNA #5 was fired. He stated there was not a question about the incident and what happened, he believed CNA #6 and it was witnessed. He stated that he never spoke with CNA #5. CNA #5 was red lined in their system (she cannot be hired again by the corporation). The Administrator stated he never interviewed CNA #5 about the incident, but she was surprised when she was fired. He said CNA #5 did not have any previous allegations of abuse before the incident. He stated there were some complaints that she was rude sometimes and her attitude was not great.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35632</p> <p>Based on record review and interview, the facility failed to follow physician orders when facility staff were having problems with a wound vacuum (wound vac; a type of therapy to help wounds heal, the device decreases air pressure on the wound and helps it heal more quickly) functioning properly for 1 (R #3) of 2 (R #3 and R #18) residents reviewed for wound vacuum care. This deficient practice of not following physician orders could likely cause the wound to go untreated, worsen, or become infected. The findings are:</p> <p>A. Record review of the face sheet for R #3 revealed she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>- Third degree burns (a serious injury that destroys all three layers of the skin: the epidermis, dermis, and hypodermis) of multiple sites on the right lower leg, foot, and ankle;</li> <li>- Seizures;</li> <li>- Cellulitis (serious bacterial infection of the skin) of right lower limb.</li> </ul> <p>B. Record review of the discharge hospital orders for R #3, dated 06/01/24, indicated R #3 was discharged from the hospital to the facility with an order for wound care. Order: First, second, and fourth toes covered with Santyl (removes dead tissue from wounds) and tegaderm (clear dressing to protect wounds). Recommend that be changed daily by the facility floor staff. Plan for Registered Nurse Wound Care (RNWC) to follow-up on 06/02/24 to 06/03/24 for another dressing change. Wound vacuum settings are negative pressure wound therapy (NPWT; a treatment that uses suction to help wounds heal) set to 125 millimeters of mercury (mmHg; a unit of pressure; a setting for the machine runs) on continuously.</p> <p>C. Record review of the physician orders for R #3, all dated 06/01/24, indicated the following orders:</p> <ul style="list-style-type: none"> <li>- As needed (PRN) order. If wound vac malfunctioned then stop wound vac, remove dressing, cleanse area with wound cleanser and apply dry dressing, notify physician.</li> <li>- PRN order. Anytime NPWT was off for over two hours, remove dressing, re-evaluate wound, contact provider, physician's assistant, nurse practitioner, or physician to obtain new orders.</li> </ul> <p>D. Record review of the Treatment Administration Record (TAR) for R #3, dated 06/01/24 through 06/07/2024, revealed staff did not document they administered the PRN wound vac orders or the PRN NPWT order.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Albuquerque Heights Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  103 Hospital Loop NE Albuquerque, NM 87109	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 08/22/24 at 11:45 am, during an interview with R #3's daughter, she stated her mother was at the hospital with 3rd degree burns to her lower leg, ankle and foot. She stated her mother had a skin graft done on her right lower leg. She said her mother was discharged from the hospital to the facility on [DATE], and when she arrived at the facility they took the dressing off so they could take pictures of the wounds. She stated the facility staff could not get the wound vac to work properly, and they tried for hours. The daughter stated if the wound vac is not working after a couple of hours then it has to be removed and a different dressing applied. She stated the facility left the same dressing on with the machine beeping and not working.</p> <p>F. Record review of the nursing progress notes for R #3, dated 06/02/24 at 1:47 pm, revealed When I came on this morning, per night shift nurse (name of nurse) that wound vac machine attached to right leg wound has been beeping and night nurse was not able to fix the issue .</p> <p>G. On 08/23/24 at 10:58 am, during an interview with Nurse #6, she stated the wound vac machine was on and beeping when she first went into R #3's room. Nurse #6 stated if the machine was beeping then it was not working properly. She stated the wound vac should not stay on longer than two hours before it needed to be taken off and a different dressing applied. She stated a wet to dry gauze (type of wound dressing that uses wet gauze or packing tape to remove drainage and dead tissue) would have been appropriate, and staff should have done that. Nurse #6 stated the nurse on duty should have notified the physician when she realized the wound vac was not functioning and she could not get it to suction properly.</p> <p>H. On 08/23/24 at 10:30 am, during an interview with Unit Manager, she stated she did not see documentation in R #3's medical record that the night nurse on 06/01/24 to 06/02/24 called the on call physician about the wound vac issues that were occurring.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50752</p> <p>Based on observation and interview, the facility failed to keep the residents free from accidents failing to safely secure the arm of his wheelchair for 1 (R #12) of 1 (R #12) residents observed for falls. This deficient practice likely resulted in R #12 falling from R #12's wheelchair that could of resulted in injury.</p> <p>The finding are:</p> <p>A. On 08/20/24 during record review, shows that R #12, facesheet indicated that he suffered from Aphsia following a non-tramaumatic intracerebral hemorrhage (stroke) affecting his right side.</p> <p>B. On 08/20/24 during record review, shows that R #12 has new onset weakness per the residents care plan on 05/16/24.</p> <p>B. On 08/20/24 at 10:40 am, during an interview with Family Member (FM) #1, she expressed concern about R #12's wheelchair arm being broken and not clipping in to the wheelchair correctly when he was in it. She stated the wheelchair was not the proper wheelchair for him, and he did not received his custom wheelchair yet.</p> <p>C. On 08/20/24 at 3:17 pm, during an observation of the 300 unit, nine residents sat in the TV area and yelled out about an imminent fall. R #12 sat near the fireplace and couches and was falling out of the left side of his wheelchair. The left arm of the the resident's wheelchair was flipped backward and was not securely clipped in place. Staff members were not present in the common area or the 300 unit nursing station. Staff were called to the common area, and three staff member responded to assist R #12.</p> <p>D. On 08/21/24 at 1:30 pm, during an interview with Registered Nurse (RN) #1, she stated R #12's wheelchair was not properly clicked when he fell out of his chair on 08/20/24. She stated the Certified Nursing Assistant (CNA; unknown CNA) stated she checked R #12's wheelchair and the armrest was secured when she put the resident in his chair that morning. RN #1 stated R #12 did not have the strength or the range of motion to unclip the armrest. She said if the armrest was properly clipped, then it would have prevented R #12 from falling out of his chair.</p> <p>E. On 08/21/24 at 02:30 pm, during an interview with the Director of Occupational Therapist (OT), the OT stated she did not hear anything about the resident's wheelchair possibly being broken. She stated the wheelchair's armrests clicked into place to ensure the safety of R #12. The Director stated R #12 did not have range of motion movement to get out of his wheelchair. The Director stated the resident's wheelchair fit him well and was not too narrow. The Director stated it was important for staff to click the wheelchair arms correctly for resident safety.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>35632</p> <p>Based on observation and interview the facility failed to ensure call lights in the residents' rooms were within reach of the resident while in bed or were accessible to them if they were in their wheelchair in the room for 6 residents (R #4, #5, #6, #7, #9 and #10) out of 7 (R #4, #5, #6, #7, #9, #10 and #11) reviewed for call lights. If the call lights are not accessible to the residents then their needs could likely go unidentified. The findings are:</p> <p>A. On 08/20/24 at approximately 12:30 pm, observations of the 300 unit revealed the following:</p> <ul style="list-style-type: none"> <li>- R #4 was in his wheelchair, and the call light was on the floor by the wall out of reach.</li> <li>- R #5 was asleep in bed, and the call light was observed on the floor out of reach.</li> <li>- R #6 was in bed and ate her lunch. The call light was on the desk behind her where she could not reach it.</li> <li>- R #7 was in her wheelchair by the bed, and the call light was on the floor by the curtain out of reach.</li> <li>- R #9 was in bed and ate lunch. The call light was wrapped around the bed rail behind her where she could not reach it.</li> <li>- R #10 lay in bed and her call light was wrapped around the feeding tube stand not in reach.</li> </ul> <p>B. On 08/20/24 at 1:00 pm, during an interview with Certified Nursing Assistant (CNA) #4, she stated the call lights should be within reach for the residents. She stated the call lights should not be on the floor or wrapped around the bed rails or the feeding tube stand.</p>