STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325069	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albuquerque Heights Healthcare and Rehabilitation	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50752 Based on observation and interview, the facility failed to protect a treatment cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) from unauthorized access when staff failed to lock the treatment carts while staff were away from the cart. This failure had the potential to affect all 48 residents on the 300 Unit, as identified by the Resident Census provided by the Administrator on 04/07/25. If staff fail to lock an unsupervised treatment cart, then residents could obtain medial equipment which could result in injury or death. The findings are: A. On 04/07/25 at 11:50 AM, during an observation of the 300 Unit, the intravenous (IV; in the vein) treatment cart was unlocked and opened. Further observations revealed the cart had sterile needles and intravenous catheters (a thin, flexible tube inserted into a vein to deliver fluids). Staff were not present in the area near the cart. B. On 04/07/25 at 11:55 AM, during an interview, Registered Nurse (RN) #1 stated the IV treatment cart was unlocked and opened. She said the treatment cart should be locked when the cart was not in use. C. On 04/15/25 at 2:15 PM, during an interview, Director of Nursing (DON) stated staff should never leave the IV treatment carts unlocked while unattended.

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on interview and record review, the facility failed to promptly notify the ordering provider of critical laboratory results for 1 (R #180) of 1 (R #180) resident reviewed for change in condition. This deficient practice could cause a delay in treatment, creating a potential for harm or death to the resident. The findings are: A, Record review of R #180's face sheet revealed an admitted [DATE] with the following diagnoses: - Hepatitis C (inflammation of the liver), - Type II diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar), - Angina pectoris (a type of chest pain caused by reduced blood flow to the heart) with presence of aortocornonary bypass graft (heart bypass surgery; a procedure to restore blood flow to areas of your heart), - Right foot amputation (loss of foot), - Stage 4 severe chronic kidney disease (severe loss of kidney function), - Staphylococcus (bacteria that causes infection) - Psoas muscle (located in the pelvic area) abscess (collection of puss due to an infection.) B. Record review of R #180's lab results, ordered and collected on 03/07/25, revealed the following: - On 03/08/25, some of the lab work came back as critical (Critical lab work results indicate a life-threatening condition and require immediate notification to the responsible healthcare provider for prompt action). - On 03/08/25 at 3:58 am, the lab called the facility, but staff did not answer. - On 03/08/25 at 4:34 am, the lab called the facility, but staff did not answer. - On 03/08/25 at 5:07 am, the lab called the facility, but staff did not answer. - A note, dated 03/08/25, directed staff to call the lab, Please call the lab regarding critical lab values. Unable to reach facility upon numerous attempts made. C. Record review of R #180's lab results, ordered and collected on 03/14/25, revealed the following: (continued on next page)

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 03/15/25, some of the lab work that was completed came back as critical. - On 03/15/25 at 3:27 am, the lab called the facility, but staff did not answer. - On 03/15/25 at 4:11 am, the lab called the facility, but staff did not answer. - On 03/15/25 at 4:49 am, the lab called the facility, but staff did not answer. - A note dated, 03/15/25, on the lab work directed staff to call the lab, Please call the lab regarding critical lab values. Unable to reach facility upon numerous attempts made. D. Record review of R #180's medical record revealed staff did not document they called the lab back on 03/08/25 or 03/15/25. E. On 04/08/25 at 9:30 am during an interview with the Nurse #10, she stated when she came on shift on 03/15/25 at 6:00 am, she did not know labs were drawn the day before. She stated no one passed the information down to her when she came on shift. She stated the nurse that entered the order and called the lab should have passed down the information. She stated she found out about the labs because R #180's wife told her about them. Nurse #10 stated she went to R #180's medical chart and saw the resident's lab was critical and out of range. She stated she was relieved R #180's wife said something to her, because the resident needed to be go the hospital immediately. Nurse #10 stated the process for getting information like lab work was not very good. She stated she did not have the information she needed, because she did not receive the information from the night shift nurse during the shift change report. She stated the information should be passed down in report at shift change. She stated if the shift did not have the information, then they could not pass it down to the oncoming shift. She stated the night shift nurse would not have any information regarding lab work to report to her since they missed the lab's phone calls. E. On 04/11/25 at 8:58 am, during an interview with the Director of Nursing (DON), she stated the facility received a lot of complaints about family or providers unable to reach staff when they called the facility. She stated the facility did not have a message system, and callers were not able to leave a message. The DON stated the lab would immediately call the facility if a resident had critical lab results. The DON stated it was expected for staff to get critical labs to the provider as soon as possible, preferably the same day.