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	08/14/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a comprehensive care plan that included interventions for transfer assistance consistent with the resident's assessed needs and physician orders for 1 (R #4) of 1 (R #4) resident reviewed. If the facility fails to develop and implement a comprehensive care plan regarding a resident's transfer requirements, then staff may attempt unsafe transfer methods that increase the risk of falls, fractures, and other serious injuries. The findings are: A. Record review of the facility's Transfer and Lift policy, dated 03/01/24, stated residents requiring extensive or total assistance with transfers must be transferred using a mechanical lift with the assistance of two trained staff members. B. Record review of R #4's face sheet showed she was admitted to the facility on [DATE], diagnosis of muscle weakness. C. Record review of R #4's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 07/03/2025, revealed she was dependent for all activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating), including transfers, and required a mechanical lift with two staff members. D. Record review of R #4's physician orders, dated 07/03/2025, revealed an order for bed rest with every two hours with hourly turns every shift. The resident was permitted activity only as tolerated, with no independent transfers. E. Record review of R #4's care plan revealed the care plan did not contain documentation the resident required two staff members assistance or the use of a Hoyer/mechanical lift for transfers. F. On 08/14/2025 at 10:40 a.m., during an interview with the Administrator, she stated it was her expectation R #4's care plan should contain interventions addressing R #4's transfer needs, including two staff members assistance and mechanical lift use.

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