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No. 0938-0391

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 12/12/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and interviews, the facility failed to provide reasonable accommodation of needs for 1 (R #4) of 1 (R #4) resident reviewed by ensuring a call light was within reach. This deficient practice is likely to result in the residents not being able to call for help when needed. The findings are: A. On 12/11/25 at 7:55 am, during an observation and interview with R #4, R #4 was observed yelling from her room asking staff for help. R #4 stated she wanted a nurse because she was in pain and needed her pain medication. R #4's call light was under R #4's bed, stuck in between the bed wheels, and out of reach for R #4. R #4 confirmed she could not reach her call light, and she needed a nurse to administer pain medication. B. On 12/11/25 at 8:00 am, during an interview with Certified Nursing Assistant (CNA) #1, she confirmed R #4's call light was not within reach for R #4. CNA #1 stated R #4's call light should be within reach at all times.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to maintain an environment that was clean and sanitary for 1 (R #4) of 1 (R #4) resident reviewed for a homelike environment by not maintaining and regularly cleaning a resident's room. If the facility fails to maintain a homelike environment, then residents are likely to feel uncomfortable and could exacerbate (make worse) health issues. The findings are: A. On 12/11/25 at 7:55 am during an observation of R #4's room, R #4's room was unclean with a large area of dried liquid on the floor. Dried footprints were present indicating someone had walked through the liquid, leaving footprints on the floor. There was a napkin stuck on the dry liquid, with other tissues and unidentified debris on the floor. The floor appeared as if it had not been cleaned for several days. B. On 12/11/25 at 7:58 am, during an interview with R #4, she stated she had not seen housekeeping in her room for several days and she wanted her floor cleaned. C. On 12/11/25 at 8:15 am during an observation of R #4's room, R #4's room was dirty with the same large, dried liquid area still present. Trash and debris were still present on the floor. D. On 12/12/25 at 10:05 am during an interview with the Housekeeping District Manager (HDM), she stated the resident rooms should be cleaned and mopped daily. She stated the Housekeeping Manager will check to make sure resident rooms are being cleaned properly and thoroughly. The HDM confirmed R #4's room was dirty and the floor should have been cleaned sooner. E. On 12/12/25 at 1:30 pm during an interview with HDM, she stated she spoke with the housekeeper responsible for R #4's room and she confirmed R #4's room was not cleaned on 12/11/2025 but should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to meet professional standards of practice for 3 (R #1, #4, and #7) of 3 (R #1, #4, and #7) residents when: R #1 and R #7 were not administered medications per physician orders. Transportation was not consistently provided to R #1, R #4, and R #7 for appointments. If the facility is not adhering to professional standards for quality improvement, then residents are unlikely to get the highest quality of care. The findings are: Repeat DeficienciesMedication Administration: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: End stage renal disease (ESRD; chronic irreversible kidney failure),Dependence on renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys cannot function properly),Type 2 diabetes mellitus with neuropathy (DM2; a disease in which the body cannot make or properly use insulin and can cause nerve damage). B. Record review of the physician orders for R #1 revealed the following: Gabapentin (anxiety medication) started on 11/24/25. Give two 100 mg (milligram) capsules three times per day for anxiety, crying and insomnia (inability to sleep). Atorvastatin (high cholesterol medication) started on 07/01/23. Give 40 mg at bedtime. Protonix (esophageal reflux medication) started on 08/25/25. Give 40 mg, 1 tablet by mouth at bedtime for esophageal reflux. C. Record review of R #1's Medication Administration Record (MAR) dated 12/01/25 revealed the following: Gabapentin,Atorvastatin,Protonix,All medications were scheduled to be administered to R #1 by 8:00 pm each night, but they were administered at midnight (12/02/25). D. Record review of R #1's summary to provider note dated 12/02/25 revealed R #1 informed the day shift nurse that the night nurse did not give her the 8:00 pm medications (due on 12/01/25) until midnight (12/02/25). E. On 12/11/25 at 9:30 am during an interview with Unit Manager (UM) #1, she stated R #1 informed her on 12/02/25 that she (R #1) did not get her medications until midnight (12/02/25), and she was supposed to get them at 8:00 pm on 12/01/25. The UM #1 confirmed R #1's medications should have been administered on time per physician orders and they were not. F. On 12/10/25 at 12:35 pm during an interview with Director of Nursing (DON), she stated R #1 did not get her Atorvastatin, Protonix, and Gabapentin on 12/01/25 as ordered and should have. R #7: G. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] with the following diagnoses: End stage renal disease.Dependence on renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly),Type 2 diabetes mellitus with neuropathy (DM2; a disease in which the body cannot make or properly use insulin and can cause nerve damage).Polyneuropathy (damage to multiple peripheral nerves, leading to symptoms such as pain, numbness, and weakness, often caused by systemic diseases like diabetes). H. Record review of R #7's physician orders dated 11/16/25 revealed the following: Gabapentin Oral Capsule for neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), give 100 mg by mouth at bedtime.Remeron for depression and appetite, give 30 mg by mouth one time per day. Tylenol for pain, give 325 mg three times per day. I. Record review of R #7's Medication Administration Record (MAR) dated 12/01/25 revealed the following: Gabapentin,Remeron,Tylenol,All medications were scheduled to be administered to R #7 by 9:00 pm each night. These medications were documented as being administered at midnight on 12/02/25. J. Record review of R #7's summary to provider note dated 12/02/25 at 5:33 pm, revealed R #7 informed the day shift nurse that the night nurse did not give him the 9:00 pm medications (due on 12/01/25). K. Record review of R #7's care plan meeting notes dated 12/03/25 at 10:35 am, indicated during the care plan meeting, R #7 stated he was not administered his medications during the night of 12/01/25. L. On 12/11/25 at 9:30 am during (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview with UM #1, she stated she was told by R #7 that he did not receive any medications during the night of 12/01/25. UM #1 confirmed R #7 did not receive his night medications on 12/01/25 and should have. M. On 12/10/25 at 12:15 pm, during an interview with the Administrator (ADM), she stated she spoke to the night shift nurse who worked on 12/01/25, and that nurse confirmed the medications for R #7 were not administered, even though he marked on the MAR that they were. N. On 12/10/25 at 12:35 pm, during an interview with Director of Nursing (DON), she stated when they investigated the late and missing medications that occurred on 12/01/25, both R #1 and R #7 were the affected residents. The DON also stated the night shift nurse told her medications were documented as being administered, but not all the medications were administered to R #1 and R #7. The DON stated that R #1 got her medications late and R #7 did not receive his medications on the night of 12/01/25. Missed Appointments: R #1: O. Refer to F0698 for related findings.R #4: P. On 12/10/25 at 7:45 am, during an observation of the facility's front door, R #4 was waiting by the front door with a Certified Nursing Assistant (CNA) and UM #1 waiting for transportation to an appointment. Q. On 12/10/25 at 7:50 am, during an interview with UM #1, she stated R #4 had a follow-up appointment related to recent eye surgery, and the appointment was scheduled for 8:30 am (on 12/10/25). R. On 12/10/25 at 8:00 am, during an interview with UM #1, she confirmed R #4's follow-up appointment was canceled due to there being no transportation available to take R #4. R #7: S. Refer to F0698 for related findings. T. On 12/11/25 at 1:30 pm, during an interview with Medical Doctor (MD)#1, he stated his expectation is a resident should not miss any appointment due to a lack of transportation. He confirmed medical appointments are sometimes missed due to a lack of transportation, including dialysis appointments, and that should not be happening at the facility.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the residents who require dialysis (a treatment that helps remove waste products and excess fluids from the blood when the kidneys are not functioning properly) receive such services, consistent with professional standards of practice and physician orders for 2 (R #1 and R #7) of 4 (R #1, R #7 R #9 and R #10) residents reviewed for dialysis, when:The facility failed to provide adequate transportation to ensure residents attended scheduled dialysis treatments. This deficient practice led to the hospitalization of R #1 and R #7. If the facility is unable to meet the appointment needs for residents receiving dialysis treatments, then residents are likely to receive inadequate care and experience health complications. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: End stage renal disease (ESRD; chronic irreversible kidney failure),Dependence on renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys cannot function properly),Type 2 diabetes mellitus with neuropathy (DM2; a disease in which the body cannot make or properly use insulin and can cause nerve damage). B. Record review of R #1's physician orders dated 04/04/25 revealed R #1 had dialysis treatments on Monday, Wednesday and Friday. C. Record review of R #1's nursing progress note dated 10/06/25 at 3:41 pm, indicated R #1 had dialysis on Monday, Wednesday, and Friday. R #1 did not go to dialysis on 10/06/25 due to the transportation company failing to arrive at the facility. R #1's most recent dialysis appointment occurred on 10/03/25. D. Record review of R #1's change in condition note dated 10/07/25 at 11:02 am, revealed R #1 had a complaint of distension (enlarged or swollen due to internal pressure) and fluid overload due to missed dialysis appointment on 10/06/25 because transportation was not available to take R #1 to dialysis. The note recommendation indicated R #1 should be transported to the hospital. E. Record review of R #1's hospital records dated 10/07/25 at 6:11 pm revealed the following: History and Physical: R #1 presents with missed dialysis due to arranged transport missing scheduled pick-up time. R #1 stated feeling of fullness to abdomen and shortness of breath due to volume overload. Review of Systems: indicated activity change and appetite change, shortness of breath, abdominal pain and nausea, with some dizziness.Physical exam: abdomen (stomach) indicated some distension (enlarged or swollen due to internal pressure) with abdominal tenderness.Labs: Potassium 7.4 high (normal range is 3.5-5.1), blood urea nitrogen (BUN test measures how much urea nitrogen is in your blood. It helps a healthcare provider determine if your kidneys are working as they should) 82 high (normal range is 6-27), Creatinine (key indicator of kidney function) 11.28 high (normal range is 0.55-1.02). Assessment and Plan: Hyperkalemia (high potassium levels in the blood) due to missed dialysis, urgent dialysis, and repeat potassium lab. F. Record review of R #1's provider an encounter progress note dated 10/19/25, revealed Hospital Course: R #1 is on dialysis due to end stage renal disease, presented to the hospital for volume overload from missed dialysis appointment due to arranged transport not picking up R #1. R #1 was taken to the hospital on [DATE] for fluid volume overload. R #7: G. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] with the following diagnoses: End stage renal disease (ESRD; chronic irreversible kidney failure),Dependence on renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly),Type 2 diabetes mellitus with neuropathy (DM2; a disease in which the body cannot make or properly use insulin and can cause nerve damage).Polyneuropathy (damage to multiple peripheral nerves, leading to symptoms such as pain, numbness, and weakness, often caused by systemic diseases like diabetes). H. Record review of R #7's nursing progress notes dated 10/01/25 through (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/06/25 revealed the following: 10/07/25 at 2:42 pm: R #7 did not go to dialysis on 10/07/25 due to transportation failing to arrive at the facility. Appointment was rescheduled to 10/08/25. 11/11/25 at 9:17 am: R #7 did not go to dialysis on 11/11/25 due to transportation failing to arrive at the facility. 11/12/25: R #7 was discharged to the hospital. 12/06/25 at 5:30 am: R #7 was waiting for dialysis transportation. Transportation services were called but they did not answer. R #7 remains at nursing home (missed appointment due to transportation failing to arrive at the facility). Appointment was rescheduled to 12/08/25. I. Record review of R #7's provider encounter notes dated 11/12/25 revealed the following: 1st call: R #7 with end-stage renal disease on dialysis and hypertension (high blood pressure) who presents with acute deterioration after missing his scheduled dialysis session on Tuesday (11/11/25). R #7 reports feeling cold, chills, shaking, and has a low-grade fever of 101 F (degrees Fahrenheit). He has not urinated in two days and has noticeable body swelling. 2nd call: called nursing facility for update on R #7 who was previously evaluated for fever, hypertension, and hypoxia (low oxygen levels) following a missed dialysis session. He has not noted any improvement since the prior evaluation.Nursing observations, evaluation, and recommendations are: R #7 noted with low grade fever and worsening confusion. Worthy of noting, R #7 missed dialysis on Tuesday 11/11/25. On-call provider gave order to send R #7 to the hospital. J. Record review of R #7's hospital Discharge summary dated [DATE] revealed the following: R #7 was presented to hospital with fever and chills. R #7 had emergent dialysis in the emergency room due to hyperkalemia (high potassium in the blood) from missed dialysis appointment due to transportation issues. admitted for acute metabolic encephalopathy (a change in how your brain works due to an underlying condition, causes confusion, memory loss and loss of consciousness) likely due to missed dialysis and sepsis (a life-threatening condition that occurs when the body's response to an infection causes injury to its own tissues and organs), most likely due to pneumonia (infection that causes inflammation in the lungs). K. On 12/11/25 at 11:26 am, during an interview with R #7, he stated he misses dialysis a lot because of transportation. R #7 stated that when he misses an appointment, sometimes he will go the next day and sometimes he must wait until the next appointment. R #7 also stated he went to the hospital in November 2025 after he missed a dialysis appointment. L. On 12/10/25 at 12:53 pm during an interview with Director of Nursing (DON), she stated the facility uses a resident's insurance to schedule transportation to appointments prior to utilizing the facility transport services. She stated the insurance company transportation is not dependable and they will often fail to show up for appointments or they won't notify the facility if they will be late picking up residents. M. On 12/10/25 at 12:59 pm, during an interview with Scheduler (SCH), she stated she sets up transportation for appointments, and she is required to utilize the resident's insurance transportation first before using the facilities transportation service. The SCH confirmed the outside transportation services are not dependable and have missed four medical appointments so far in December 2025. N. On 12/11/25 at 8:45 am, during an interview with the DON, she stated residents missing dialysis is a problem, because dialysis is essential for residents who require it. O. On 12/11/25 at 9:30 am during an interview with UM#1, she stated residents are often waiting in the front of the facility, ready to go to their appointments, and transportation will not arrive. P. On 12/11/25 at 1:30 pm, during an interview with Medical Doctor (MD)#1, he stated his expectation is a resident should not miss any appointment due to a lack of transportation. He confirmed dialysis appointments are sometimes missed due to a lack of transportation, and that should not happen. The MD #1 confirmed it was concerning that R #1 and R#7 were both hospitalized after missing dialysis treatments. Q. On 12/12/25 at 11:22 pm during an interview with DON, she stated her expectation for the dialysis residents would be to follow their plan of care which (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	states they receive dialysis three times per week. She stated if a dialysis appointment is missed, it can cause the resident to become hemodynamically unstable (insufficient blood flow in the body symptoms can include high blood pressure or heart disease).

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure dental services were obtained to replace dentures (removable plate or frame holding one or more artificial teeth) for 1 (R #5) of 1 (R #5) resident reviewed for dental care and services. This deficient practice could likely result in the residents not receiving dental care and services to meet their needs. The findings are: A. Record review of the facility's dental service policy dated 09/15/25, indicated the facility is responsible for the loss or damage of dentures when the loss or damage is due to the facilities staff's misplacement, inadvertent disposal, and/or destruction of the dentures. B. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE] with the following diagnosis: Severe protein calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). C. Record review of R #5's Brief Interview of mental Status (BIMS; a screening for cognitive impairment, scores range from 00 to 15 with 00 to 7 indicating severe impairment, 8 to 12 is moderately impaired, and 13 to 15 is cognitively intact) dated 11/09/25, revealed R #5 had a score of 13, which indicated R #5 was cognitively intact. D. Record review of R #5's personal effects inventory sheet dated 11/08/25 indicated she had upper and lower dentures upon admission into the facility. E. Record review of R #5's admission progress note (EENT- eyes, ears, nose, throat section) dated 11/08/25 revealed R #5 wore dentures. F. Record review of R #5's provider encounter progress note dated 11/10/25 indicated R #5 needed a dental referral for dentures. G. Record review of R #5's physician orders dated 11/10/25 revealed R #5 required a dental referral for denture replacements. H. On 12/10/25 at 12:56 pm, during an interview with the Scheduler (SCH), she stated she had not set up a denture replacement appointment for R #5 because she was told R #5 lost her dentures at the hospital. The SCH confirmed there was a denture replacement physician order in R #5's medical record. She stated a dental appointment should have been made for R #5 to replace her dentures, but that did not happen. I. On 12/11/25 at 8:45 am, during an observation and interview with R #5, R #5 sat on her bed and appeared to be edentulous (did not have teeth). R #5 stated she had her dentures for one or two days after she was admitted into the facility on [DATE], and they have been missing ever since (after being lost in the facility). R #5 stated she reported it to the facility staff, but the only thing she had heard about her missing dentures was the facility was working on it. She stated she feels embarrassed when she does not have her teeth in and she wants the facility to schedule an appointment to replace her lost dentures. J. On 12/11/25 at 12:35 pm, during an interview with Director of Nursing (DON), she stated she had not seen R #5 with dentures. She stated she was unaware until today (12/11/25) that R #5 had missing dentures. The DON confirmed R #5 had her dentures documented on the inventory sheet when she arrived on 11/08/25, and a dental referral should have been made for R #5 per the physician orders.