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	12/31/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to protect residents from the potential for accidents and hazards for 1 (R #20) of 4 (R #s 20, #21, #22 and #23) residents reviewed for falls by not preventing a resident from falling out of bed. This deficient practice could likely cause a resident to suffer health consequences such as a broken bone or a head injury. The findings are: A. Record review of R #20's face sheet revealed R #20 was admitted into the facility on [DATE] with the following diagnoses: Aphasia (inability or difficulty communicating),Hemiplegia cerebral infarction affecting right dominant side (paralysis of the arm, leg, and trunk on the same side of the body),Contracture (a shortening of muscles around joints causing joint stiffness and immobility). B. Record review of R #20's Minimum Data Set assessment (MDS; a federally mandated assessment instrument completed by facility staff) revealed R #20 was dependent for all of his activities of daily living (ADL's include dressing, eating, moving in bed, toileting and bathing) and had impairment (substantially limits movement) on both lower extremities (both legs) and impairment one side with his upper extremity (arm). C. Record review of R #20's Kardex (electronic documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) dated 05/14/24 indicated nursing staff are to transfer R #20 via mechanical lift (two person) assist. D. Record review of R #20's care plan dated 10/29/25 revealed the following: Bed in low position, Ensure all equipment ready and in the room prior to patient care. E. Record review of R #20's nursing progress notes dated 10/28/25 at 10:50 am revealed the Certified Nursing Assistant #1 (CNA) attending to R #20, left the room to get the Hoyer lift (mechanical lift) and another staff member to assist with the Hoyer lift. CNA #1 did not lower the bed or move R #20 to the center of the bed before leaving the room. R #20 was left on the edge of the bed, and the bed was in high position. When CNA #1 returned to the room, R #20 was on the floor. The nurse was informed and did a head-to-toe assessment on R #20. R #20 was found to have an abrasion (scrape) to the left lateral knee (outer side of the knee joint). Neurological checks (an assessment to ensure there was no trauma to the brain) were initiated. F. Record review of R #20's nursing progress notes, change in condition dated 10/28/25 revealed provider recommendations to monitor for changes. Wound care order for the abrasion was put in place, triple antibiotic ointment cover with foam dressing. R #20 was stable, and nurse will continue to do neurological checks and monitor for pain. G. On 12/31/25 at 8:52 am, during an interview with the Unit Manager (UM)/Assistant Director of Nursing (ADON) #1, she stated she went into R #20's room right after he was found on the floor. She stated R #20 was dependent on staff for assistance, but he did not require two people assist with the exception of using the Hoyer lift. She stated when she spoke to CNA #1 about the incident (on 10/28/25), and CNA #1 told her she dressed R #20 and was able to get the Hoyer lift sling under him. She then left the room to find another staff member and the Hoyer lift. The UM #1 stated CNA #1 had left the room unattended with the bed in high position for several minutes, and left R #20 towards the edge of bed instead of in the middle of the bed. The UM/ADON #1 confirmed this was not the appropriate practice, and R #20's bed was still in a high position when she arrived in R #20's room after the fall. H. On 12/31/25 at 10:25 am, during an interview with Registered Nurse (RN) #1, she stated she spoke with CNA #1 and confirmed with the CNA what she did wrong. RN #1 stated CNA #1confirmed she should not have left the room with the bed in high position while R #20 was on the edge of the bed. RN #1 stated R #20 has spastic movements he is not able to control, which is why R #20 needed to be in the middle of the bed for his safety.