

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 02/03/2026
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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care)?was accurate for 1 (R #1) of (R #1) resident reviewed for PASRR accuracy. This deficient practice is likely to result in the facility not providing the services needed by residents who are identified in the screening process for additional care and services.The findings are:Record review of the facility's Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients policy, revised 02/16/24, revealed the Social Worker or designated staff will assure all patients with mental disorders and intellectual disability received appropriate pre-admission screenings according to Federal and State regulations. The policy stated if a PASARR was not completed or was incorrect, then Social Services would coordinate with the appropriate agency to conduct the evaluation, review PASARR results to determine care needs, and incorporate recommendations into the patient's assessment and care planning.Record review of R #1's facesheet revealed she was admitted to the facility on [DATE] and diagnosed on [DATE] with diagnosis of:Major DepressionGeneralized Anxiety Disorder. Record review of R #'s PASRR Level I Identification Screening, dated 12/10/25, revealed staff documented the resident did not have a diagnosis of or a suspected mental illness.On 02/03/26 at 9:00 am, during an interview with Social Worker (SW), she revealed the R #1 was diagnosed with Depression and Anxiety on 12/11/25 after her admission to the facility. She stated the PASRR should have revised to reflex the current diagnosis.On 02/03/26 at 11:00 am, during an interview with Administrator she stated it is her expectations the PASRR would have been revised with the new diagnosis.

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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents had a safe and functional environment throughout the facility, as evidenced by failure to: Ensure bed footboards were maintained in safe working condition and free from damage. Ensure food remains was promptly cleaned from resident room floors. Ensure the 100-unit water dispenser area remained in good repair. Ensure laminate wooden floor slats were intact and not broken. Ensure the handrail in the 300 unit was free from damage. Ensure the 300 unit remained free from urine odors. These deficient practices exposed residents in the 100, 300, and 400 units to an unsafe and uncomfortable environment. The findings are: 100 Unit A. On 02/02/26 at 9:45 a.m., during an observation of the 100-unit water dispenser area, observation revealed the water dispenser was positioned on a countertop with visible water damage to the surrounding surface. The countertop was darkened and discolored areas consistent with prolonged moisture exposure. The laminate surface broken and with water damage along the edges near the sink and water dispenser. The cabinet door beneath the countertop had a loose handle that was partially detached and hanging at an angle. Observation revealed multiple broken laminate wooden floor slats near the nursing station. 300 Unit B. On 02/02/26 at 8:45 a.m., during an observation of the 300-unit, observation revealed a strong urine odor around rooms [ROOM NUMBER]. C. On 02/02/26 at 1:34 p.m., during an observation of the 300-unit, observation revealed a strong urine odor upon entry into the unit, including the common area where residents were seated watching television. D. On 02/03/26 at 9:32 a.m., during an observation of the 300-unit, observation revealed a strong urine odor upon entry into the unit, including the common area where residents were seated watching television. E. On 02/03/26 at 8:16 a.m., during an observation of the hallway in the 300-unit, Section 3, outside Rooms 314-319 next to the linen closet, observation revealed the wall-mounted handrail was damaged. The lower protective cover beneath the handrail was cracked and partially broken, with a jagged section approximately ten inches long. 400 Unit F. On 02/02/26 at 11:25 a.m., during an observation of room [ROOM NUMBER], observation revealed the resident occupying Bed B was sleeping in her bed. [NAME] leafy food and multiple plastic condiment cups were present on the floor underneath the bedside table located on the left side of the resident's bed. During the same observation, occupied Bed A was observed to have a broken footboard. G. On 02/02/26 at 1:45 p.m., during an interview with R #4, she stated she dropped her salad during dinner the previous evening 02/01/25 and no staff came to clean it up even after her request for assistance. She stated the food remaining on the floor made her feel bad and she stated by leaving food on the floor could attract cockroaches. H. On 02/03/26 at 10:15 a.m., during an interview with the Maintenance Director (MD), he stated it was his expectation that the 100-unit water dispenser area would remain in good repair. He stated flooring should be maintained in good condition because damaged flooring could create a tripping hazard for residents. He further stated the handrail in the 300 unit required repair and that the footboard of the bed in room [ROOM NUMBER] A should have been properly bolted to prevent potential injury. I. On 02/03/26 at 10:17 a.m., during an interview with the Administrator, she stated the 300 unit should not have heavy urine odors. She stated it was her expectation that Certified Nursing Assistants (CNAs) and housekeeping staff clean resident areas to prevent urine odors. J. On 02/03/26 at 10:32 a.m., during an interview with the District Manager of Housekeeping, she stated housekeeping cleans the facility daily. She stated she was present in the building for most of the previous day and did not identify urine odors related to bedding at that time. She stated if urine odors are repeatedly identified, housekeeping reports the concern through the Quality Control Inspection (QCI) process and checks the room for cleanliness. She stated</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>housekeeping uses Rapid disinfectants when cleaning resident rooms and that urine odors can occur when bedding is not changed in a timely manner. She stated it was her expectation that hallways remain free of urine odors and that staff clean spills or soiled areas when observed.K. On 02/03/26 at 10:43 a.m., during an interview with the Director of Nursing (DON), she stated it was her expectation that if a resident drops food on the floor, a CNA or nursing staff clean the food when they see it. She further stated if a resident urinates in bed, CNAs are expected to change the resident and replace wet or soiled bedding.</p>		