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	05/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, the facility failed to notify the facility provider (Physician, Nurse Practitioner) for 1 (R #1) of 1 (R #1) resident, when staff failed to: Report R #1's follow-up blood pressure results to the Nurse Practitioner (NP) #1 as instructed.Document each time the NP #1 was notified after R #1's blood pressure was rechecked as ordered. If resident's experience a change in condition (CIC; a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) and the facility nursing staff does not notify the provider as ordered, then residents are at an increased risk for deterioration in condition, delayed medical intervention, hospitalization, or additional complications. The findings are: A. Record review of R #1's face sheet, dated 04/23/2026, revealed the following diagnoses: Type II Diabetes (DM2, a disease in which the body cannot make or properly use insulin). Acute Cystitis (Bladder infection).Hypertension (HTN; high blood pressure).Third Degree Burns (Severe burns that destroy the skin and damage deeper tissue). B. Record review of R #1's Change in Condition Assessment, dated 05/13/2026, revealed the following:R #1 experienced a change in condition related to abnormal vital signs (body temperature, pulse rate, respiration rate (rate of breathing), oxygen saturation (amount of oxygen in the blood), and blood pressure), including a low blood pressure reading. R #1's blood pressure was 88/51 (a normal blood pressure is 120/80) on 05/13/2026 at 7:56 AM. The facility provider recommended oral fluids be administered, R #1's blood pressure be rechecked, and the results reported back to the provider. C. Record review of R #1's nursing progress notes, dated 05/14/2026, revealed the following:R #1 attended a doctor's appointment and was later sent to the emergency room (ER) due to hypotension (low blood pressure). R #1's diastolic blood pressure (the lower number in a blood pressure reading; the pressure in your arteries when your heart rests between beats) was reportedly in the 50s upon arrival to the appointment, indicating significant low blood pressure. D. On 05/22/2026 at 10:14 AM, during an interview, the Director of Nursing (DON) stated R #1 experienced episodes of hypotension on 05/11/2026 and 05/13/2026. The DON stated the Nurse Practitioner (NP) #1 was notified of R #1's hypotension on 05/13/2026, but the notification for the 05/11/2026 hypotension episode was not documented. The DON stated that her expectation is that staff report abnormal vital signs, including hypotension, to the provider because failure to do so could result in deterioration or additional complications. E. On 05/22/2026 at 10:29 AM, during an interview, Registered Nurse (RN) #1 stated she notified the NP #1 about R #1's low blood pressure and was instructed to encourage oral fluids and recheck the resident's blood pressure. RN #1 stated she failed to follow up with NP #1 and document the repeat blood pressure after oral fluids were provided to R #1. F. On 05/27/2026 at 11:07 AM, during an interview, the NP #1 stated she was notified regarding R #1's low blood pressure on 05/13/2026 and instructed nursing staff to encourage oral fluid intake, recheck the resident's blood pressure, and call back if the resident did not improve. The NP #1 stated nursing staff did not call her back with an updated blood pressure reading for R #1, so she assumed R #1's blood pressure improved with oral hydration. The NP #1 stated R #1 later attended a doctor's appointment on 05/13/2026, where the resident's diastolic blood pressure reportedly dropped into the 50s and R #1 was sent to the hospital for an evaluation due to hypotension. The NP #1 stated she should have been contacted after R #1's blood pressure was rechecked, but she was not.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews, the facility failed to ensure medications were administered as ordered for 1 (R #4) of 1 (R #4) resident, when the facility nursing staff: Failed to administer intravenous (IV; into the vein) antibiotics as ordered by a physician. If residents do not receive medications as prescribed, they may experience incomplete treatment, worsening infection, or failure to achieve the intended therapeutic effects.The findings are: A. Record review of the facility's Administration of IV Fluids and Medications, dated 10/2024, revealed the following: To correctly and aseptically (free from contamination caused by harmful bacteria, viruses, or other microorganisms; surgically sterile or sterilized) set up the primary IV bag and administration set. Close the IV clamp (a small, manual device attached to the tubing of an IV set that is used to control or stop the flow of fluids or medications into a patient's bloodstream) on the administration set. Spike the IV bag (the process of connecting an IV administration set to a fluid filled IV bag so that the solution can be delivered to a patient under sterile conditions) and hang the IV hook on the IV pole. Open and close the IV clamp. B. Record review of the facility's Medication Administration Policy, dated 01/2026, revealed the following: Medications are administered with written orders of the prescriber. Prior to administration, review and confirm medication orders for each resident.The timing of medication administration must align with manufacturer specifications. The person who prepares the dose for administration is the person who administers the dose. C. Record review of R #4's face sheet revealed an admission date of 05/01/2026 with the following diagnoses: Sepsis (a serious condition in which the body responds improperly to an infection). Endocarditis (a serious infection of the inner lining of the heart chambers and heart valves). D. Record review of R #4's physician orders, dated 05/02/2026, revealed an order for Ampicillin Sodium (antibiotic used to treat bacterial infections) 2 grams (G) to be administered intravenously every four hours until 05/31/2026. E. Record review of R #4's Change in Condition (CIC; a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) Assessment, dated 05/20/2026, revealed the following: R #4's IV antibiotic was not administered at the scheduled time because the IV tubing remained clamped (closed).R #4 received the IV antibiotic 2 hours and 30 minutes late. The physician was notified regarding the medication error. F. On 05/21/2026 at 2:42 PM, during an interview, Registered Nurse (RN) #1 stated R #4 was scheduled to receive IV Ampicillin at 6:00 AM, but the night nurse who connected the IV antibiotic to R #4, did not open the IV clamp as expected and R #4 did not receive the IV medication as ordered. RN #1 stated she identified the medication error when she was disconnecting R #4's IV antibiotic. RN #1 stated it is her expectation that residents receive medications as ordered, and if antibiotics are not administered as prescribed, then residents may experience incomplete treatment or worsening infection. G. On 05/21/2026 at 3:26 PM, during an interview, the Unit Manager (UM) stated a CIC was initiated for R #1 after the IV tubing was found clamped and the physician was notified, which required R #4's IV antibiotic administration times to be adjusted. The UM stated the night nurse did not release the IV clamp and R #4 did not receive the scheduled IV antibiotics as prescribed. The UM stated it is her expectation that all residents receive medications as ordered by a physician. H. On 05/22/2026 at 2:55 PM, during an interview, the Director of Nursing (DON) stated it is her expectation that all residents receive antibiotics and medications as ordered by a physician. The DON stated if a resident does not receive their antibiotic regimen as ordered, it could extend or alter the course of the antibiotic treatment. The DON stated R #4 should have received the IV antibiotic as ordered but did not.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement a physician-ordered therapeutic diet for 1 (R #1) of 1 (R #1) resident, when the facility staff failed to: Provide a controlled carbohydrate (consistent or controlled; a meal plan designed to keep carbohydrate intake fairly equal at each meal and snack throughout the day and week to help stabilize blood sugar levels) diabetic diet as ordered by a physician for R #1. If physician-ordered therapeutic diets are not implemented as prescribed, then residents are likely to experience elevated blood sugars, difficulty chewing, inadequate nutritional intake, and an increased risk for further complications. The findings are: A. Record review of the facility's Food and Nutrition Policy, dated 05/01/2023, revealed diets are to be provided as ordered by the physician. B. Record review of R #1's face sheet revealed a re-admission date of 04/30/26 with the following diagnoses: Type II Diabetes (DM2; a disease in which the body cannot make or properly use insulin).Malnutrition (not consuming enough protein and calories).Pressure Ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin). C. Record review of R #1's hospital discharge orders, dated 04/30/2026, revealed R #1 was ordered to receive a diabetic diet. D. Record review of R #1's facility admission summary, dated [DATE], revealed R #1 was to receive a diabetic diet while in the facility. E. Record review of R #1's Nurse Practitioner (NP) #1 progress notes revealed the following: Dated 05/02/2026, R #1 is prescribed a controlled carbohydrate diet.Dated 05/07/2026, R #1 is prescribed a controlled carbohydrate diet. Dated 05/11/2026, R #1 is prescribed a controlled carbohydrate diet. F. On 05/18/2026 at 4:43 PM, during an interview, R #1's niece expressed concerns regarding the resident's nutrition. R #1's niece stated R #1 had diabetes and difficulty chewing due to not having teeth. R #1's niece stated during a care conference on 05/13/2026, she requested R #1's diet be changed to an easy chew diabetic diet. G. On 05/22/2026 at 2:33 PM, during an interview, the Registered Dietitian (RD) stated it is her expectation that residents diagnosed with diabetes receive a consistent carbohydrate diabetic diet, and residents without teeth receive an altered texture diet appropriate for chewing difficulties. The RD stated the resident diets must match the physician's diet orders from the hospital. The RD stated if a resident's diet does not match their diagnosis, chewing ability, or physician orders, then it could affect their blood sugar control, cause difficulty in chewing, discomfort, or result in poor nutrition. The RD stated R #1 should be receiving a controlled carbohydrate diabetic diet as ordered. H. On 05/22/2026 at 2:51 PM, during an interview, the Director of Nursing (DON) stated residents with diabetes or difficulty chewing due to poor oral health should receive diets appropriate to their needs. The DON stated if dietary needs were not properly assessed or followed, it can negatively impact the resident's nutrition and overall health. I. On 05/27/2026 at 11:07 AM, during an interview, the Nurse Practitioner (NP) #1 stated residents with hospital orders for a diabetic diet should receive the ordered therapeutic diet. The NP #1 stated if the diabetic diet order was not entered into the electronic health record, the resident could receive a regular diet, which could cause their blood sugars to increase.