

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/11/2025
NAME OF PROVIDER OR SUPPLIER  Manzano Del Sol by Purehealth		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 Roma Avenue NE Albuquerque, NM 87108	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interview, the facility failed to complete and submit a Five Day Report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations) to the State Agency regarding allegations of neglect (the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress) for 1 (R #77) of 1 (R #77) resident. If the facility does not submit follow-up reports, then the State Agency cannot assure the residents are safe and free of neglect. The findings are: A. Record review of R #77's Face Sheet revealed an initial admission date of 06/20/25 with the following diagnoses:- Cardiomyopathy (heart disease),- Type 2 diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar),- Unspecified Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),- Hypoxemia (low levels of oxygen in the blood),- Atherosclerosis heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls). B. Record review of the facility's Facility Reported Incident (FRI), dated 06/24/25, revealed R #77 fell shortly after admission on [DATE] and fell again later that evening. The FRI did not report the time of the falls. The FRI documented R #77 complained of pain on 06/24/25, which resulted in the diagnosis of a right femoral neck fracture (a break in the neck of the right thigh bone, located just below the ball of the right hip joint). C. Record review of R #77's Electronic Health Record, revealed R #77 was discharged to the hospital on [DATE]. Further review revealed the facility did not document any evidence the facility completed an investigation into the resident's falls or fracture of the right thigh. D. On 08/07/25 at 1:50 pm, during an interview, Director of Nursing (DON) stated she did not complete an investigation into the resident's falls, because the resident did not return to the facility after being hospitalized. The DON stated she was aware the Five Day Follow-Up report was due on the fifth day after an incident was reported to the State Agency.</p>

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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